H.R. 4859, PART II, HEALTHIER FEDS AND FAMILIES: INTRODUCING INFORMATION TECHNOLOGY INTO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON THE FEDERAL WORKFORCE AND AGENCY ORGANIZATION

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

ON

H.R. 4859

TO AMEND CHAPTER 89 OF TITLE 5, UNITED STATES CODE, TO PROVIDE FOR THE IMPLEMENTATION OF A SYSTEM OF ELECTRONIC HEALTH RECORDS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

JUNE 13, 2006

Serial No. 109–215

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpoaccess.gov/congress/index.html
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

33–251 PDF WASHINGTON : 2007

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H.R. 4859, PART II, HEALTHIER FEDS AND FAMILIES: INTRODUCING INFORMATION TECHNOLOGY INTO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

TUESDAY, JUNE 13, 2006

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON FEDERAL WORKFORCE AND AGENCY ORGANIZATION,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 2154, Rayburn House Office Building, Hon. Jon C. Porter (chairman of the subcommittee) presiding.

Present: Representatives Porter, Marchant, Schmidt, Davis of Illinois, Norton, and Clay.

Staff present: Ronald Martinson, staff director; Chad Bungard, deputy staff director/chief counsel; Shannon Meade, professional staff member; Patrick Jennings, OPM detailee/senior counsel; Chad Christofferson and Alex Cooper, legislative assistants; Adam Bordes, Tania Shand, and Mark Stephenson, minority professional staff members; and Neil Shader, minority staff assistant.

Mr. PORTER. I'd like to bring the meeting to order. I appreciate you all being here today.

This is a hearing on Healthier Feds and Families: Introducing Information Technology into the Federal Employees Health Benefits Program, a Legislative Hearing on H.R. 4859, Part II.

We will probably be called for votes here momentarily, but I do know we have a special guest with us, so I'd like to do my opening and then have Mr. Clay give his opening, and then, by that time, we should be taking a recess for probably 15, 20 minutes.

So, again, thank you all for being here. This is the third hearing that I've chaired that will examine the need to improve the quality and delivery of healthcare within the Federal Employee's Health Benefits Program and the second hearing that focuses on the bill that I and Representative Lacy Clay from Missouri have introduced; that's H.R. 4859, the Federal Family Health Information Technology Act.

As a primary sponsor of H.R. 4859, I often get asked by Federal employees and others the following question: How will electronic health records [EHR], proposed in my bill help the employees? Well, it's quite simple and clear. What the last two hearings have taught us is that the EHR, as proposed under H.R. 4859, will reduce medical errors, lower the cost of healthcare and improve qual-

ity of care while at the same time empowering consumers by giving them and their providers access to critical information about their health status and medical needs.

At the last hearing on H.R. 4859, former Speaker of the House Newt Gingrich stated from his testimony, which was extremely powerful, that paper kills. He continued: Instead of saving lives, our current paper-based health system is taking them, with as many as 98,000 Americans still being killed by medical errors every year. Ridding the system of paper-based records and quickly adopting health information technology will save lives and at the same time save money.

H.R. 4859 will also improve the quality of care. At that same hearing, IBM testified that the implementation of personal electronic health records for its employees has played a major part in making IBMers healthier and others in the industry, and lowering healthcare premiums. Substantially reducing medical errors and improving the quality and delivery of care within the FEHBP will be a welcomed improvement in and of itself, but like the old commercials for the ginseng knives used to say, but, wait, there's more, the implementation of H.R. 4859 should lower the cost of healthcare for all the participants in FEHBP over time.

In my home State of Nevada, Health Plan of Nevada's transition from paper records to electronic records have saved them nearly $1.7 million to date, resulting from a more than 50 percent reduction in medical records, staffing and paperwork.

In drafting H.R. 4859, my staff and I have met with over three dozen different stakeholders, including trade organizations, nonprofit organizations, hospitals, various companies, employee groups and Federal agencies. I have very much appreciated their advice and input from all of them and have learned a great deal.

Staff and I have also examined many demonstration projects using electronic health records, including regional health information organizations, and have gone to physician offices and hospitals to see the effectiveness of health information technology firsthand.

The reason that we have invested so much time on this legislation is because we want to do it right. I'm pleased to announce that, in addition to some of the organizations with us today, the Federal Family Health Insurance Health Information Technology Act has received a significant amount of public support, including Mr. Newt Gingrich, the Health Information Management Systems Society, which has almost 300 corporate members, IBM corporation, the ERISA Industry Committee and U.S. Chamber of Commerce, among many others.

Additionally, in its program carrier letter for fiscal year 2007, issued a month after the introduction of H.R. 4859, the Office of Personnel Management for the first time expressed its expectations that carriers will work toward creating carrier-based and personal electronic health records.

The Federal Family Health Information Technology Act is designed to provide the voluntary electronic health records to the FEHBP participants cost free while at the same time maintaining strict adherence to HIPAA. This means that, during implementation, carriers will be unable to pass costs on to FEHBP participants because all carriers must contract with OPM annually. I believe

this explicit requirement will be a reality, especially with continued aggressive congressional oversight. Moreover, if history is any indication, the implementation of H.R. 4859 could also lead to lower premiums.

The Federal Family Health Information Technology Act requires carriers participating in the Federal Employees Health Benefits Program to provide their members with two types of electronic records, a carrier-based electronic health record and a personal electronic health record. The carrier-based electronic health record will provide valuable information by leveraging the claims data, technology and capabilities of health plans to improve healthcare decisions by patients and providers. This claims information already exists and is maintained by the carrier. In fact, most carriers use this claims-based information for disease and care management. The bill simply requires a carrier to make it available for a member. It is a shame that many carriers do not make this information available to their members today.

The trend, however, is looking up as many carriers are moving in this direction, such as United Health Care and Blue Cross Blue Shield of Texas, Delaware and Illinois, just to list a few. The bill will require that carriers that want to do business with and participate in FEHBP make this information available upon request to its members.

Contracts between OPM and insurance carriers also will require carriers, upon the request of a member, to provide for the establishment and maintenance of a personal electronic health record for their members. This record will be controlled by the individual, and it will contain personal health information the individual chooses to include, such as personal and family health histories, symptoms, over-the-counter medication use, diet, exercise or other relevant health information activities. The creation of a personal electronic-based health record will simply provide program participants with greater control over their health information.

The bill also requires the carriers to make electronic health records available in some portable fashion to all requesting FEHBP members.

With the 109th Congress heading toward a close, I intend to move forward in short order—I like to say we're moving toward a close; we're being very optimistic—I intend to move forward in the short order on subcommittee consideration of H.R. 4859. However, let me reemphasize the commitment to getting this bill right. That is what these hearings are about and the countless meetings and discussions on this bill that I've had to date.

Based on some of these discussions, I've already agreed to work on some changes. Both the National Association of Active and Retired Federal Employees and the National Treasury Employees Union have expressed uneasiness about our inclusion of a provision that would allow the unused portion of FEHBP's 1 percent administrative fee to be made available to help fund the implementation of electronic health records. I've agreed to eliminate that provision at this time prior to mark-up. In addition, all employee groups with us today, NARFE, NTEU and the American Federation of Government Employees have expressed concern about certain older annuitants or employees who are not computer savvy or lack access to

a Web-based portal but who should have the same ability to access and input information into the electronic health records as those who are computer savvy. This is an important concern and a matter that must be dealt with accordingly, and I look forward to working with these groups on appropriate language prior to the mark-up.

It's also important to clarify that H.R. 4859 does not intend in any way to get ahead of standards being developed and is intended to provide both flexibility for appropriate market determinations and for OPM to administer the program. The Office of National Coordinator for Health Information Technology within the Department of Health and Human Services is fostering certification and harmonizing standards by creating a cooperative environment within and outside the Federal Government to ensure that consensus industry standards are developed and adapted in both the private and the public sectors. The certification process will determine whether the particular products, like electronic health records, meet minimum requirements as identified by the industry-led cooperative effort.

Another process already underway will identify harmonized standards to ensure that a full array of nonconflicting standards is available to the industry. I'll continue to work with HHS prior to the mark-up to get technical assistance to ensure that H.R. 4859 does not get ahead of the game with regard to standards and does not inadvertently lead to conflicting standards which could be a barrier to interoperability and patient portability of health information.

Privacy remains a major concern for a number of individuals, and rightly so, especially in light of the recent theft of data from the Veterans' Affairs employees. There is nothing more personal and private than a person's medical information. The Federal Family Health Information Technology Act intends to ensure that a participant's medical information is kept private and secure by requiring compliance with the Health Insurance Portability and Accountability Act.

HHS has committed to provide technical assistance to ensure that the language in H.R. 4859, which is intended to be wholly consistent with and not modify HIPAA, does not inadvertently alter it in any way.

In addition, there are some great minds at HHS thinking long and hard about this important issue, particularly through the work of the Health Information Security and Privacy Collaboration. HHS should also at some point consider revising the regulations to ensure HIPAA is adequate and strong enough to protect our privacy.

Technology has been booming in America and in the world over the past couple of decades. As always, change has been harder for some to accept than others. Change is always hard, especially technological change because it involves a change of culture as well.

Some doctors see the benefits of electronic health records, and some are stuck to paper. Some carriers are leading change and providing carrier-based electronic health records and personal electronic health records to their members as the bill proposes, and some are waiting for the last possible moment before they have to provide this level of information to their members.

The Federal Family Health Information Technology Act is not for show or some kind of exercise in futility; it's about improving the quality and the delivery of healthcare within the Federal Employees Health Benefits Program. The technology is available today. The technology will save and improve lives. It's here today, it's being used around the country. We cannot in good conscience continue to deny existing information held by carriers to be used for treatment. To keep ignoring the substantial benefits associated with the health information technology is to allow senseless deaths caused by preventable medical errors to continue to prevent the highest possible quality of healthcare to be delivered. This is akin to a hospital rushing an individual to a hospital without using an ambulance. The Federal Employees Health Benefits Program cannot afford to wait any longer; to do so would unnecessarily cost lives, health and productivity and of course money.

I look forward to the discussions today and to all of our witnesses' testimony, and I would now like to introduce my colleague, Mr. Lacy Clay, for some comments.

Thank you for being here.

[The text of H.R. 4859 follows:]

I

109TH CONGRESS
2D SESSION

H. R. 4859

To amend chapter 89 of title 5, United States Code, to provide for the implementation of a system of electronic health records under the Federal Employees Health Benefits Program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 2, 2006

Mr. PORTER (for himself and Mr. CLAY) introduced the following bill; which was referred to the Committee on Government Reform

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A BILL

To amend chapter 89 of title 5, United States Code, to provide for the implementation of a system of electronic health records under the Federal Employees Health Benefits Program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Family Health Information Technology Act of 2006".

SEC. 2. ELECTRONIC HEALTH RECORDS.

(a) IN GENERAL.—Chapter 89 of title 5, United States Code, is amended by inserting after section 8902a the following:

"§ 8902b. Electronic health records

"(a) This section provides for the establishment, in connection with the program established under this chapter, of electronic health records for each covered individual, including—

"(1) requiring the establishment of a carrier electronic health record under subsection (b);

"(2) requiring the offering by carriers to covered individuals of a personal electronic health record under subsection (c); and

"(3) providing carrier-based incentives for establishing provider-based electronic health records under subsection (d).

"(b)(1) Each contract under this chapter shall require that the carrier establish, maintain, and make available, in accordance with standards adopted by the Office of Personnel Management under this section, a carrier electronic health record for each covered individual who is enrolled under this chapter in a health benefits plan offered by the carrier.

"(2)(A) A carrier electronic health record for a covered individual under this subsection shall consist of a car-

rier's health information on the individual's health care claims, health care services data, or both, such as information describing the individual's inpatient facility admissions, emergency room visits, and claims for prescription drugs. Such a record shall include, to the maximum extent practicable, such information as it relates to claims or services for another carrier in which the covered individual was previously enrolled under this title.

"(B) The information under subparagraph (A) shall cover the period beginning on the later of January 1, 2008, or the date of the covered individual's enrollment with the carrier under this title. Such period is not required to be longer than the period specified in standards adopted by the Office of Personnel Management under this section.

"(C) In the case of a covered individual who changes enrollment under this title after the effective date specified in paragraph (4) from one carrier to another carrier, the first carrier shall transfer information from the carrier electronic health record under this subsection to the second carrier to the extent specified by the Office of Personnel Management by not later than 90 days after the date the first carrier receives notice of the change in enrollment.

"(3) Information from a carrier electronic health record for a covered individual shall be made available to the individual and shall be made available (in accordance with the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996) to a health care provider treating the individual. A carrier shall make such information available, in accordance with standards adopted under this section—

"(A) promptly;

"(B) over a secure internet or other electronic-based connection;

"(C) in a format useful for diagnosis and treatment; and

"(D) in a format that permits its importation into a personal electronic health record under subsection (c).

"(4) The previous provisions of this subsection shall apply with respect to contracts for contract years beginning with—

"(A) the 3rd contract year (or 4th contract year, if the Office of Personnel Management determines that carriers are not prepared to implement the previous provisions of this subsection by such

3rd contract year) beginning after the date of the enactment of this section; or

"(B) such earlier contract year as the Office of Personnel Management may determine.

"(c)(1) Each contract under this chapter shall require the carrier in accordance with standards adopted under this section—

"(A) to provide, upon the request of a covered individual, for the establishment and maintenance of a personal electronic health record for the individual;

"(B) to establish a method for the individual to access the individual's personal electronic health record through a mechanism that is integrated with access to the carrier electronic health record for the individual under subsection (b); and

"(C) to establish a method for the individual to transfer the individual's personal electronic health record to the individual (or to a carrier or other entity designated by the individual) upon the request of the individual at any time, including at the time of disenrollment of the individual.

"(2) A personal electronic health record for a covered individual shall consist of such personal health information, such as family health history, symptoms, use of over-the-counter medication, diet, exercise, and other relevant

health information and activities, as the individual may provide. Such record may also include information from a provider-based electronic health record referred to in subsection (d) as well as from a carrier electronic health record.

"(3) Each contract under this chapter shall require the carrier to enable health information to be imported in standard electronic format into a personal electronic health record from a provider-based electronic health record and from a carrier electronic health record consistent with standards adopted by the Office.

"(4) Nothing in this subsection shall be construed as authorizing the carrier or another person, other than a covered individual, to access a personal electronic health record of the individual without the authorization of the individual.

"(5) The previous provisions of this subsection shall apply with respect to contracts for contract years beginning with the contract year beginning after the first contract year with respect to which the requirements of subsection (b) are in effect under subsection (b)(4).

"(d)(1) Each contract under this chapter shall require the carrier to provide, in accordance with standards adopted by the Office under this section, incentives (subject to the availability of amounts from the Federal Fam-

ily Health Information Technology Trust Fund, as established by section 4 of the Federal Family Health Information Technology Act of 2006) for providers to implement a comprehensive system of provider-based electronic health records for all patients covered by the contract.

"(2) The previous provisions of this subsection shall be effective with respect to contract years beginning with such contract year as the Office of Personnel Management shall determine.

"(e) Beginning with the contract year beginning after the first contract year with respect to which the requirements of subsection (b) are in effect, each carrier shall report to the Office of Personnel Management its progress and plan for enabling each covered individual, upon request, to store and access, through a portable, electronic medium, the individual's personal electronic health record established under subsection (c), as well as the carrier electronic health record for the individual (established under subsection (b)) and provider-based electronic health records relating to the individual referred to in subsection (d). Such plan shall provide a means for such storage and access through such a portable medium beginning with the 5th contract year after the first contract year with respect to which the requirements of subsection (b) are in effect.

"(f)(1) Standards adopted under this section regarding carrier, personal, and provider-based electronic health records shall be consistent with any standards for interoperability of electronic health records developed by ONCHIT.

"(2) In addition to paragraph (1), the Office of Personnel Management shall consult with ONCHIT in the implementation of this section, including the establishment of effective dates under subsections (b)(4)(B) and (d)(2).

"(3) For purposes of this subsection, the term 'ONCHIT' means the Office of the National Coordinator for Health Information Technology in the Department of Health and Human Services, and includes any successor to the functions performed by such Office.

"(g)(1) The Office of Personnel Management may waive any or all of the requirements of this section for a carrier described in paragraph (2) insofar as the carrier has established an electronic health record system that substantially meets the purpose of each such requirement that is waived.

"(2) A carrier described in this paragraph is a carrier that—

"(A) is an integrated health care system that combines the functions of a health plan, hospitals, pharmacy, laboratories, and clinicians; and

"(B) has developed and is implementing, as of the date of the enactment of this section, a provider-based comprehensive electronic medical record for each member of the health plan.

"(h) For purposes of this section, the term 'covered individual' has the meaning given such term by section 8902a(a)(1)(B).".

(b) CONFORMING AMENDMENTS.—(1) Section 8902 of title 5, United States Code, is amended by adding at the end the following:

"(p) A contract may not be made which is not in conformance with the requirements of section 8902b, except that the Office of Personnel Management may phase in or waive conformance with some or all of such requirements during the first two contract years in which a carrier has a contract under this title.".

(2) The table of sections for chapter 89 of such title is amended by inserting after the item relating to section 8902a the following:

"8902b. Electronic health records.".

SEC. 3. PROVISION REGARDING RATES.

During the period ending with the contract year following the first contract year with respect to which the requirements of subsection (b) of section 8902b of title 5, United States Code, as inserted by section 2(a), are in effect, in determining rates under section 8902(i) of

such title, the Office of Personnel Management shall not take into account any carrier administrative costs, monetary savings, or return on investment resulting from implementation of carrier and personal electronic health records required under subsections (b) and (c) of such section 8902b, except that the Office shall have access to the unused portion of contributions set aside in the Employees Health Benefits Fund under section 8909(b)(1) of such title without fiscal year limitation for such use as the Office considers necessary to assist carriers in complying with such subsections.

SEC. 4. FEDERAL FAMILY HEALTH INFORMATION TECHNOLOGY TRUST FUND.

(a) IN GENERAL.—The Office of Personnel Management shall establish the Federal Family Health Information Technology Trust Fund (in this section referred to as the "Trust Fund") for the purpose of receiving donations to be used to award grants to carriers who meet certain requirements as set forth by the Office.

(b) ACCEPTANCE OF DONATIONS.—In accordance with the section, the Office may accept donations made to the Trust Fund. Donations made to the Trust Fund, and grants awarded from such Fund to carriers, shall not be considered to be the solicitation or payment of remuneration of any kind, nor shall receipt of such grants be

considered an inducement to refer, purchase, order, or lease any good, facility, item, or service.

(c) DEPOSIT OF AMOUNTS RECEIVED.—Funds received by the Office under this section shall be transmitted by the Office to the Trust Fund.

(d) FUNDS TO BE USED FOR CARRIER GRANTS.—The Office shall award grants from the Trust Fund to carriers under chapter 89 of title 5, United States Code, to be distributed under section 8902b(d) of such title as incentives to their contracting health care providers for implementing provider-based electronic health records based on requirements and qualifications set forth by the Office and standards adopted under section 8902b(f) of such title.

SEC. 5. IMPLEMENTATION.

The Office of Personnel Management shall provide for the implementation of this Act through appropriate administrative guidance, which may be by regulation, by carrier letter, or otherwise.

SEC. 6. HIPAA COMPLIANCE.

Nothing in this Act shall be construed as affecting the application or compliance with regulations promulgated pursuant to section 264(c) of the Health Insurance

Portability and Accountability Act of 1996 (relating to access to and disclosure of health information).

○

Mr. CLAY. Thank you very much.

Mr. Chairman, let me begin by expressing my gratitude to you, Mr. Chairman, for inviting me to formally address the Federal Workforce Subcommittee this afternoon. It has been both an honor and privilege working with you on health IT issues.

As I believe, health IT has the potential to benefit our public health infrastructure for generations to come. In 2003, the Institute of Medicine estimated our total national expenditures on healthcare to be approximately $1.7 trillion of our economy. Much of this is driven by government efforts to make the provision of healthcare a public good for all to benefit from. Through programs such as Medicare and Medicaid as well as some insurance programs for Federal employees, we have sought to provide equality among all individuals needing healthcare, regardless of socioeconomic need or circumstances.

From this perspective, I believe it is time for the Federal Government to lead in the development and adaptation of a nationwide health information network that can diminish such barriers and improve upon the quality of care provided to all of our citizens.

The widespread adoption of health information technology will provide a platform for delivering higher quality care more efficiently and economically than current paper-based record information systems.

No better example of this can be offered than from my home State of Missouri where Medicaid providers and chronically ill patients are working to develop Web-based collaborative medical records that will ensure improved case management and treatment options for our participants. Since the enactment of the Health Insurance Portability and Accountability Act of 1996, the adaptation of electronic health information among private industry has made significant progress. A recent report from the Center for Study in Health System Change validates this assessment, as recent surveys indicate that the number of doctors having access to information technology for key clinical activities such as e-prescribing has nearly doubled to about 20 percent since 2001.

Nevertheless, this is still only one-fifth of our Nation's doctors, and more needs to be done in order to achieve widespread access across geographic and socioeconomic boundaries.

Furthermore, vendor requirements for information security and stringent uniform privacy standards that exceed current HIPAA regulations must be established if patients are to have confidence in e-health solutions. The only way to achieve these outcomes, I believe, is through the leadership of the Federal Government. This is why I have partnered with Chairman Porter on legislation that will strengthen the Federal Government's role in health information technology.

I am a proud co-sponsor of H.R. 4859, the Federal Family Health Information Technology Act of 2006, as authored by Chairman Porter. Simply put, this bill utilizes the market power of the Federal Government by establishing a process for the development of electronic health records for all Federal employees.

By utilizing our Federal Employees Health Benefits Program as a model for electronic health record adaptation, we are creating a

model for consumers, employers and insurers to build comprehensive electronic health records for all individuals.

I've also introduced H.R. 4832, the Electronic Health Information Technology Act of 2006, along With Chairman Porter. H.R. 4832 seeks to accomplish two major goals: First, it will codify the current Office of the National Coordinator for Health Information Technology at HHS and preserve its role as the leading health information technology standard setting authority in the Federal Government. Second, the bill seeks to partner with the private sector through grants in a direct loan program that will provide key economic assistance for institutions seeking to expand their electronic health record capabilities.

If we continue our pursuit of utilizing IT throughout the healthcare delivery system, we are sure to experience shorter hospital stays, improved management of chronic disease and the reduction in the number of needles tests and examinations administered over time. While it is not a panacea, I believe the creation of such a network will prove far more efficient in both economic and human terms than its financial cost.

Mr. Chairman, this concludes my remarks, and I ask that they be included in the record.

Mr. PORTER. With no objection.

Thank you, Mr. Clay. I appreciate your hard work and your efforts to improve healthcare. Thank you very much.

We are going to go into recess for a few moments to go have votes on the floor. But shortly after the recess, I am going to embarrass a couple of friends that are here, so I'm first going to recess.

[Recess.]

Mr. PORTER. I'd like to bring the meeting back to order. Thank you for your patience. I appreciate everyone still being here.

And as I was rushing out to vote, I did have an opportunity to recognize my good friend, Ron Martinson, on his 25th wedding anniversary, he and Wanda. And again, it's an honor for me to do that, and I'm sorry we had to do that in a hurry, but congratulations.

Also, I would like to formerly acknowledge that Mr. Clay will be serving as part of the committee.

Lacy, again, thank you for your testimony earlier.

And I'd like to now turn over to Mr. Davis for an opening statement.

Mr. DAVIS OF ILLINOIS. Well, thank you very much, Mr. Chairman. And let me apologize for coming a bit late, but I also want to congratulate Mr. Martinson on his 25th wedding anniversary. Anybody who stays married for 25 years in this day and age deserves some commendation. As a matter of fact, that's what kept me away; we had a bill promoting responsible fatherhood on the floor that I was managing, so that's why I wasn't here. So he fit right in with that.

But let me just thank you, Mr. Chairman, for calling this hearing and for calling this meeting, but also for the leadership that you've provided to this subcommittee. And it has certainly been a pleasure working with you.

Chairman Porter, H.R. 4859, the Federal Family Health Information Technology Act, which you sponsored with Representative Clay, is a very forward-thinking bill with a very worthwhile objective, to improve the quality and delivery of healthcare for Federal Employees Health Benefits Program, the FEHBP participants.

An integrated system of medical records could be particularly beneficial to a patient being treated for a complex condition by a number of different specialists. All of the treating physicians would be able to access all of the patients' records, lessening the possibility that one physician would prescribe a treatment that would interact improperly with the treatment prescribed by another physician.

While the bill pushes us in the direction of using technology to collect, store, retrieve and transfer health information electronically, many important questions and concerns remain. For example, one, do insurance providers collect the type of data that would be useful for diagnosis and treatment as the bill requires? The insurance claims data may record the date and cost of a patient's blood tests, but do they record the results of the blood tests? Under the bill, providers would be required to create and make available a carrier-based—that is, electronic health record—for all covered individuals and to a healthcare provider treating the individual. As unwise as it may seem, what if an enrollee simply does not want an electronic health record and if such a file were created, which health provider would the file be transmitted to?

In addition to the privacy concerns, there is the question of interoperability. The Office of Personnel Management and America's health insurance plans indicate that the bill would create a proliferation of numerous personal health record models and make standardization and interoperability very difficult to achieve. It has been suggested that a pilot program testing personal electronic health records of FEHBP enrollees may be a better way to proceed. I hope that our witnesses will address this option in their testimony.

Again, Mr. Chairman, I want to thank you. And I was just thinking that when I first worked in the community health centers, the first task that I had was to help develop something called a problem-oriented medical records program some years ago. So I come to this with a little bit of not only interest, but also some experience, and it's delightful to see us move in this direction. And so I commend you and Mr. Clay for introducing this legislation and look forward to our witnesses.

Mr. PORTER. Thank you, Mr. Davis. We do need your expertise, so we're glad you're a part of this team.

Mr. Clay, anything you would like to add at this time? You're more than welcome to.

Mr. CLAY. No.

Mr. PORTER. I'd like to do some procedural matters. First all of, I ask unanimous consent that all Members have 5 legislative days to submit written statements and questions for the hearing record and any answers to the written questions provided by the witnesses also be included in the record. Without objection, it is so ordered.

I ask unanimous consent that all exhibits, documents and other materials referred to by Members and the witnesses may be included in the hearing record, and that all Members be permitted to revise and extend their remarks. Without objection, it is so ordered.

And it's also the practice of this committee to administer the oath to all witnesses. If all the witnesses would please stand, I will administer the oath at one time.

[Witnesses sworn.]

Mr. PORTER. Let the record reflect all witnesses have answered in the affirmative. And please be seated at this time.

I'd like to invite our first witness to the table, I believe he is already with us. The witness will be recognized for an opening statement. I would ask you to summarize your testimony in about 5 minutes if at all possible. Any further statements you may wish will be included in the record.

Of course we have heard from Mr. Clay at this point, so we will now move into Mr. Dan Green. We appreciate you being here. Deputy Associate Director with the Center for Employee and Family Support Policy at the Office of Personnel Management, and I thank you for being here.

STATEMENT OF DAN GREEN, DEPUTY ASSOCIATE DIRECTOR, CENTER FOR EMPLOYEE AND FAMILY SUPPORT POLICY, OFFICE OF PERSONNEL MANAGEMENT

Mr. GREEN. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, thank you for your invitation to discuss H.R. 4859. I am here to speak about OPM's role in administering the Federal Employees Health Benefits Program. The FEHBP program covers approximately 800 employees and their families. The program offers competitive health benefits products for Federal workers like large private sector employers by contracting with private sector health plans. OPM has consistently encouraged FEHBP plans to be responsive to consumer interests by emphasizing flexibility and consumer choice as key features of the program. In our call letter last year, we encouraged carriers to take steps to expand and improve on their health information technology efforts. While there are wide variations in the scope and extent of information technology currently being used by FEHBP carriers, most are focusing their efforts on providing claims-based information through their Web sites linking disease management problems to HIT initiatives and prescribing e-prescribing incentives.

This year, we encouraged FEHBP plans to make personal claims data available to enrollees, to continue working with their pharmacy benefit managers to provide incentives for e-prescribing, to link their disease management programs to HIT and to ensure compliance with Federal requirements that protect the privacy of individually identifiable health information.

In our call letter, we also ask FEHBP carriers to develop business plans with action items and milestones for accelerating HIT for the remainder of 2006 and for 2007. We also plan to expand our Web site information to highlight the HIT capabilities and plans so

that prospective enrollees can view this information in reviewing their health plan choices for 2007.

We are committed to confronting the rising cost of healthcare, to help members of the Federal family afford the insurance coverage they need. We believe transparency in healthcare costs and quality can help patients better control their medical expenses. Therefore, we are taking steps in the FEHBP program to raise the level of transparency.

This year's call letter asks carriers to make pricing information available to enrollees. Director Linda Springer and senior staff personally met with a number of carriers to urge them to provide specific information on their Web sites to help consumers make better informed choices during this year's open season. We are encouraging carriers to administer online decision tools with cost estimators related to both diagnosis and drugs to group costs for common illnesses and conditions by geographic area, and to ensure that they describe the sources, limitations and currency of the data clearly and prominently on their Web sites.

Our commitment to transparency aligns with our efforts to promote wider use of HIT. IT will provide for standardized interoperable medical, pharmaceutical and laboratory costs and utilization information. Making this information more transparent to consumers will help them to understand the value of personal health information in managing their own health needs and their healthcare expenses.

There is much HIT research and development activity underway. Under an HHS contract, the Health Information Technology Standards Panel is developing a process for a set of health IT standards that will support interoperability among healthcare software applications. The HITSP standards, the first of which are expected to be delivered this September, will form the basis for implementation of new HIT initiatives. OPM intends to join other Federal health programs in ensuring that these standards are adopted as soon as possible.

OPM appreciates your interest in health information technology as shown by your introduction of legislation H.R. 4859. And while we agree with the legislation in principle, we do have some concerns with some of its provisions. We believe that rather than stressing the need for a carrier-based personal health record, the bill should focus more on the implementation of interoperability standards covering carrier information. Health information, whether it originates from the carrier or the provider, can be most useful to consumers when the information is available in a standardized format.

The bill provides for an incentive plan that will allow OPM to provide funds to carriers to help their contract and medical providers adopt interoperable technology systems. This is an innovative concept. The FEHBP program, though, has no experience in operating a charitable trust fund as envisioned in the bill for administering the grant process.

Finally, I would like to express our support for your attention to the very important issue of privacy and security of personal health information.

H.R. 4859 recognizes that consumers have a right to privacy. We believe privacy is an important consumer concern, and that no compromise will be acceptable.

We appreciate this opportunity to testify before the subcommittee and look forward to working with you on furthering the Health Information Technology Initiative. I'll be glad to answer any questions you may have.

[The prepared statement of Mr. Green follows:]

STATEMENT OF
DANIEL A. GREEN
DEPUTY ASSOCIATE DIRECTOR
CENTER FOR EMPLOYEE AND FAMILY SUPPORT POLICY
STRATEGIC HUMAN RESOURCES POLICY DIVISION
OFFICE OF PERSONNEL MANAGEMENT

before the

SUBCOMMITTEE ON THE FEDERAL WORKFORCE
AND AGENCY ORGANIZATION
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

on

Health Information Technology

June 13, 2006

Mr. Chairman and Members of the Subcommittee, thank you for inviting me here today to discuss H.R. 4859 and OPM's role in promoting the adoption of health information technology (HIT) in the Federal Employees Health Benefits (FEHB) Program.

Background

As the administrator of the one of the country's largest employee health insurance programs, OPM plays a key role in fulfilling President Bush's vision of making health information easily accessible to consumers

through the adoption of advanced technologies. In fact, OPM is a member of two distinguished Federal organizations: the American Health Information Community, a Federally-chartered commission charged with developing recommendations for HHS on how to facilitate the adoption of health information technology and the Interagency Health IT Policy Council, which was established to coordinate federal health information technology policy decisions across Federal Departments and agencies that will drive federal action necessary to realize the President's goals of widespread health IT adoption.

Administering the Federal Employees Health Benefit Program

OPM administers the Federal Employees Health Benefits (FEHB) Program which covers approximately 8 million Federal employees, retirees and their dependents and offers competitive health benefits products for Federal workers, much like large employer purchasers in the private sector, by contracting with private sector health plans. Over the years OPM has consistently encouraged participating health plans to be responsive to consumer interests by emphasizing flexibility and consumer choice as key features of the program. Adoption of health information technology is

another important consumer oriented healthcare improvement that is being pursued by many of our healthcare insurers.

In our efforts to ensure healthcare rates are competitive and consumer choice is maximized, we are encouraging the use of technology for medical record keeping purposes and for many provider-to-consumer processes. For example, in our April 19, 2005 Call Letter, we strongly encouraged carriers to take steps to expand and improve on their health information technology efforts. While there are wide variations in the scope and extent of information technology currently being used by FEHB carriers, most are focusing their efforts on providing claims-based information through their web sites, linking disease management programs to HIT initiatives, and providing e-Prescribing incentives.

Our work with FEHB carriers and the work we are engaged in with the Department of Health and Human Services (HHS) and others has helped us focus our near-term efforts to further the President's initiatives. By that I mean OPM is encouraging FEHB plans to enhance their consumer education efforts to make them more aware of how HIT can help to achieve improvement in healthcare quality and improve efficiency. We are also

encouraging carriers to make personal claims data available to enrollees. We are encouraging carriers to continue working with their pharmacy benefit managers to provide incentives for ePrescribing, to link their disease management programs to HIT, and to ensure compliance with Federal requirements that protect the privacy of individually identifiable health information.

This year's Call Letter was issued on April 4 and we asked FEHB carriers to develop business plans with action items and milestones for accelerating HIT for the remainder of CY 2006 and for CY 2007. We also plan to expand our web site information to highlight the HIT capabilities of participating plans so that prospective enrollees can view this information in reviewing their health plan choices for 2007.

We are committed to confronting the rising cost of healthcare to help members of the Federal family afford the insurance coverage they need. This commitment is also reflected in our goals to strengthen the patient-physician relationship through cost and quality transparency. We believe greater transparency in healthcare costs and quality can help patients better control their medical expenses. Therefore, we are taking steps in the FEHB

Program to raise the level of transparency that is available to enrollees for both provider cost and health plan quality by the end of this year.

For instance, this year's Call letter asked carriers to make pricing information available to enrollees. Director Linda Springer and senior staff personally met with a number of carriers to urge them to provide specific information on each plan's website to help FEHB consumers make better informed health care choices during this year's open season. We are encouraging them to add more online decision tools with cost estimators related to both diagnoses and drugs, to group costs for common illnesses and conditions by geographic area, and to ensure that they describe the sources, limitations and currency of the data clearly and prominently on their web sites.

Our commitment to transparency aligns with our efforts to promote wider use of health information technology. Each initiative supports the other. Information technology will provide for standardized interoperable medical, pharmaceutical, and laboratory cost and utilization information. Making this information more transparent to consumers will help them to understand the value of personal health information in managing their own health needs and their healthcare expenses. Together, we believe HIT and

transparency can drive better informed and more rational medical care decisions, resulting in improved efficiency and better quality care.

There is much HIT research and development activity underway. Under HHS' leadership, Federal agencies are working to gain industry consensus on a range of important decisions. These include defining the consumer's role in access and control over patient information, addressing variations in State and Federal laws on privacy issues, uniform standards for transfer of patient information from one entity to another, and compatibility of software system technology.

Dr. David Brailer, who is now the Vice-Chair of the American Health Information Community, testified before the House Ways and Means Committee in April. In his testimony, he stated that HHS had awarded a contract to the American National Standards Institute, a non-profit organization that administers and coordinates the U.S. voluntary standardization activities, to convene the Health Information Technology Standards Panel (HITSP). The HITSP brings together U.S. standards development organizations and other stakeholders. The HITSP is developing and implementing a harmonization process for achieving a

widely accepted and useful set of health IT standards that will support interoperability among healthcare software applications, particularly EHRs.

The HITSP standards, the first of which are expected to be delivered in September 2006, will form the basis for implementation of new HIT initiatives. OPM intends to join other Federal health programs in ensuring that these standards are adopted as soon as possible.

Promoting the Use of Health Information Technology

OPM appreciates your interest in this issue, as shown by your introduction of legislation, H.R. 4859, to promote the availability of electronic health records in the FEHB Program. The standards for such records are being developed under the leadership of Health and Human Services and the American Health Information Community. As the President has said, "To protect patients and improve care and reduce cost, we need a system where everyone has their own personal electronic medical records that they control and they can give a doctor when they need to."

While we agree with H.R. 4859 in principle, we do have some

concerns with some of its provisions. We believe that rather than stressing the need for a carrier based "personal health record," the bill should focus more on the implementation of interoperability standards covering carrier information. Health information – whether it originates from the carrier or the provider – can be most useful to consumers when the information is available in a standardized format.

OPM's FY 2007 Budget states that "the Administration supports the adoption of health information (IT) as a normal cost of doing business to ensure patients receive high quality care." The Administration believes that the best way to encourage providers to adopt HIT is to promote the conditions for a thriving free market. One of those conditions is national interoperability standards.

The bill provides for an incentive plan that would allow OPM to provide funds to carriers to help their contracted medical providers adopt interoperable technology systems. To finance the incentive plan, the bill establishes an OPM-administered trust fund to receive charitable donations from private sources. OPM would award grants from the trust fund to carriers which, in turn, would distribute the proceeds to their contracting

providers to help them implement electronic health records in their practices. While this in an innovative concept, the FEHB Program has no experience in operating a charitable trust fund or administering a grant process. It would extend our operational role well beyond our current responsibilities.

I would like to express our support for your attention to the important issue of the privacy and security of personal health information. H.R. 4859 recognizes that consumers have a right to privacy. We believe privacy is an important consumer concern and that no compromise will be acceptable. There are many privacy issues that must be addressed before electronic records containing personal, identifiable health information are accepted by the public at large. We are encouraged by HHS' efforts to address this important issue. We plan to work closely with HHS to ensure all necessary steps are taken to protect consumer privacy rights.

We appreciate this opportunity to testify before the Subcommittee and look forward to working with you on furthering the health information technology initiative. I will be glad to answer any questions you may have.

Mr. PORTER. Thank you, Mr. Green. We appreciate you.

And certainly all of your colleagues at OPM have been very responsive to all of our needs, and I appreciate that.

For the audience, and for the record, could you explain how a call letter works and what it means, what it does?

Mr. GREEN. Certainly, yes, sir. We contract with some 270 plan choices in the Federal Employees Health Benefits Program. In late March, early April, of each year, we issue a call letter which calls for carriers to provide to us their proposed benefit and rate changes for the next plan year. For instance, this year, on April 4th, we issued the call letter for the 2007 contract year. In that call letter——

Mr. PORTER. Excuse me, Mr. Green. So what would be a contract year? Is it October to July? Is it January——

Mr. GREEN. A contract year is a calendar year, yes, sir.

We have an open season in November, and enrollees are allowed to change plans effective the first pay period of the next year. So working backward from that, we like to, by September of the previous year, we need to have ready for all the members information about how their plans will change in the upcoming year, what the rates will be, what the benefit changes will be. And then we share that information and market that information to enrollees during the fall. So we're working backward. We need the summer to negotiate rates and benefits.

So the call letter in April asks the carriers what changes they propose for the upcoming year, and we give our guidance, the things that we expect from carriers in both rates and benefits as well as in the administration of the program and the types of things that we want them to work toward. And health information technology was one of those things. We receive their rate and benefit proposals May 31st by regulation.

Mr. PORTER. Plus it's purely optional for a company even to submit a bid or a—what is it called when they submit? Is it called a bid? Is it called a proposal?

Mr. GREEN. Well, they apply to join the FEHBP program. But all carriers that are currently in the program the previous year are sent the call letter under the assumption that they will continue. But, yes, that is correct——

Mr. PORTER. So if they choose not to follow your guidelines, or Congress, they don't have to submit a proposal.

Mr. GREEN. No, absolutely not. They can withdraw from the program at the end of any contract year.

Mr. PORTER. Thank you. So if they actuarially determine it's not profitable for them to submit their proposal again, it is purely optional.

Mr. GREEN. Precisely.

Mr. PORTER. As I said, the bill does not intend in any way to get ahead of standards, provides flexibility for appropriate market determinations and for OPM to administer the program. Will you and HHS continue to work with my staff in providing technical assistance before the subcommittee mark-up on H.R. 4859 so we can get it right and do it right the first time?

Mr. GREEN. Absolutely, sir.

Mr. PORTER. Well, I knew the answer to that, but I still needed to ask that question.

Mr. GREEN. Absolutely, we will.

Mr. PORTER. Your call letter that you sent out to the businesses did mention the accelerating HIT. Have any plans been submitted yet to address this?

Mr. GREEN. Yes, sir. We have received the rate and benefit proposals from all of our carriers as regulations proscribe by May 31st. That information is now being sifted through. We will analyze it, and we will work with carriers where we see they were incomplete in their answers or where they have innovative ideas. And during the negotiation season, during the summer, we will be analyzing that and consolidating that information and finding out where they propose to go and if that fits in with our plans as well.

Now, this is proprietary information and is not releasable until rates and benefits are announced.

Mr. PORTER. Absolutely. And I understand that.

The companies, when they receive the call letter, do you use a scoring system? What if they choose on your call letter—because it addresses other issues, not just HIT, what if they choose not to address an issue that is not in the call letter? Is there a matrix or anything else that you use to determine responsiveness?

Mr. GREEN. Yes, sir, we do have a matrix. There's a number of points. If they aren't responsive to our call letter's information, do not provide information, we go back to them and work with them until we do get the information. If they are still not responsive, we have a system that provides penalties. We negotiate profit with the plans as well, and if plans are not cooperating with our program initiatives, then they could receive a reduction in profit.

However, I hasten to add that rarely happens. Our plans, as you point out, voluntarily participate in the FEHBP program, and we've found them all to be very supportive of our initiatives, and we try to work with them to make sure that the ways we are going are the ways that benefit our common customer, our Federal employees and retirees. We have that in common with all of our health plans.

Mr. PORTER. Do you think that we'll be able to address some of the concerns that have been brought up regarding privacy and those issues? Do you think we'll be able to address that appropriately and provide the proper privacy for our participants?

Mr. GREEN. Yes, sir, I do. And we share those concerns with you and with the others that have brought them up. We have that, along with the health and welfare of our enrollees, uppermost in our minds; their right to privacy is extremely important to us. But I do believe that those issues can be addressed effectively.

Mr. PORTER. And there are a lot of success stories in the industry, and I will point out Blue Cross and Blue Shield, right after Katrina, in preparation for Rita, successfully transitioned an additional form of HIT for their company and I think to protect their participants. There are, as I said in my opening comments, I've met with dozens of folks, including insurance carriers, and there are some carriers that openly embrace this concept, and there are some that don't. And having been in the insurance industry 20 years, I understand the language; sometimes, I may not agree, but I under-

stand the culture of the insurance industry, not that I always agree with it.

But it seems to me that there are a lot of carriers that are implementing this quite successfully across the country. Are you hearing of problems with some of the carriers? And you don't have to mention names. What are you hearing?

Mr. GREEN. Well, what we're hearing from the carriers, they generally are very interested in this. I mean, after all, our FEHBP carriers are like any other companies; they will adopt changes that will make them more efficient and will allow them to better compete in the marketplace.

As you point out, the initiatives that have already been underway have proven the value of using technology, health information technology and personal health records, to not only improve operations and to save both benefit and administrative costs, but they've also attracted enrollees because they've demonstrated the company's interest in the health and well-being and the involvement of their members and their own healthcare. So I think you're going to see more and more of that adoption.

And yes, there are issues that need to be overcome. I think that the positive movement will carry forward with correct support from the government and having interoperable standards in place so that those investments—they're not buying a Beta; they're buying a VHS.

Mr. PORTER. Well said. My last comment, in having met with a lot of companies, there are those that are now using as a marketing tool to attract customers HIT, some of the hospitals and some of the insurance companies, and I see 1 day when that's going to be a TV commercial: We offer HIT because it will save lives, and it will reduce premiums.

I just appreciate all of your efforts and trust your opinion, and know that all these areas that have been addressed, it's healthy to have the debate and a discussion, and I look forward to working with you more in the future.

And with that, Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

I was just thinking, Mr. Green, what are your thoughts about the possibility of creating a pilot health information technology program for the FEHBP participants?

Mr. GREEN. We believe that a pilot can provide a good approach to evaluate how the adoption of HIT initiatives affects the healthcare system in a particular geographic area. And we are particularly interested in how FEHBP consumers deal with the availability of health information technology. So pilots can be very productive.

Mr. DAVIS OF ILLINOIS. And so you have no problem—I mean, no disposition toward not——

Mr. GREEN. No, no disposition toward not working with pilots.

Again, while we do need standards in place that apply to all pilots, we need privacy protections as would apply to all initiatives, so some things need to be across the board.

Mr. DAVIS OF ILLINOIS. H.R. 4859 makes a distinction between carrier electronic health record and a personal electronic health

record; could you share with us the difference between the two? And which one, if either, in your estimation would be most useful?

Mr. GREEN. Yes, sir. There's a lot of nomenclature issues out there in the industry about defining EHRs and PHRs and EMRs and that sort of thing, so it can be quite confusing. But the way it works for me, sir, is I think of it in terms of where the information is generated. Some information the carrier holds. And that's claims-based information; how much was paid? There is identification information about the enrollees. There are claims information. There is identification information about providers. There is laboratory cost or tests done. There is prescription drugs that are used. That's the sort of information that's carrier-based information.

There is personal health information that the individual provides that may be in other systems of records but definitely is provided by the individual, obviously identifiable information; the vaccines or the immunizations that their children have had that might not be in every provider's record. There's family history information. There's over-the-counter drugs that an individual is taking, and aches and illnesses, symptoms that the individual provides.

And then there is provider-based information, which are the diagnoses, the results of tests, the test scores as opposed to which test is performed, the actual results of the tests, some background information on why a particular test was provided, x-ray information.

So it works for me best to think about in terms of where the information came from rather than what particular title is put on any particular bit of information.

Mr. DAVIS OF ILLINOIS. Aside from the call letter, do you see any other role for OPM?

Mr. GREEN. Yes, sir. We work with our carriers 365 days a year, and 1 more day on leap years. We are there to—and we hear from our enrollees as well every day of the year. So we think we are in a very good position to help them understand the needs of our enrollees and the needs of the government that is funding the insurance plan.

So, yes, we work with them regularly, not just during the negotiation season but on individual cases and around the clock doing oversight and administrative review.

Mr. DAVIS OF ILLINOIS. Do you feel that privacy and interoperability concerns are adequately addressed in the legislation?

Mr. GREEN. I think that, while they are addressed, we can work with the staff to improve on them and address other additional concerns. But I think they're there. I think the intent is there, and we want to make sure that they comply with the law and the HITSP standards that I addressed.

Mr. DAVIS OF ILLINOIS. I have no further questions. Mr. Chairman, thank you very much.

Mr. PORTER. Mr. Clay, any questions?

Mr. CLAY. I will be very brief, Mr. Chairman.

OK, Mr. Green, please identify the deficiencies that you see in the interoperability standard setting process at HHS right now. Would OPM require its carriers to adopt the technical standards for employee records that have been developed through the Consolidated Health Initiative and the AHIC activities?

Mr. GREEN. Our Director, Linda Springer, is a member of the community, the AA community, and we are working very closely with HHS, and we intend to support the initiatives coming out of the—both by the administration and by the HITSP standards that are in place and the other initiatives as well. How we do that is—we are still working out, but we are committed to being as supportive as we can be in this process.

Mr. CLAY. Would you insist that all carriers utilize the same set of standards that are available now and as they are implemented in the future?

Mr. GREEN. The standards aren't available as of yet. The first set of standards are due in September. But we will be working to, ultimately, as the whole program—the whole 10-year initiative is designed to do, having a set of standards that are used universally. How we go about that, we have to work with the carriers and we have to work with HHS to make that happen.

Mr. CLAY. Thank you very much for your response. I have no further questions, Mr. Chairman. Thank you.

Mr. PORTER. I have an additional question, Mr. Green; and then we are going to go vote. But there is only two, so it shouldn't take very long.

I know a real concern, and rightfully so, for this committee and for the employees is the cost of insurance. Also of equal importance is saving lives and saving injuries, and if not even greater concern. Because literally, as we have said earlier, paper kills—and we already know it—80,000 or 90,000 people a year. But I know one of the concerns is that by trying so—and, by the way, I don't think this science is new. But, to some, this is new in the culture. I hear from sectors, from employees and from insurance carriers that this could drive up the cost of insurance.

Have you heard any of that yet or any indication of your call letter of any of your carriers saying we are going to have to charge more for your premiums because of what you have requested?

Mr. GREEN. No, sir, I have not heard that.

Mr. PORTER. I am really surprised. Because I heard that from a number of insurance carriers, that this may well cost more money, which has also frightened some Federal employees, that the costs could be passed on to them. So you haven't heard from any company that, by implementing this, this could save funds or cost more?

Mr. GREEN. Sir, I have not. But I can understand that might, that is out there, that it would cost. The fact is that capital improvements and expenses do cost money in the short term; and you have to spend some money to make some money. That is part—we fund administrative expenses and capital expenses, our fair share of those expenses, regularly. And it is our job—it is OPM's job to make sure that we get our return on our dollar both in benefit costs and in administrative costs. That is our job to do, and we will do that. So we are not likely to spend money wantonly. But investments cost some money. It is the return on investment that we look for.

Mr. PORTER. Including saving lives, and I know that is——

Mr. GREEN. That is important, too.

Mr. PORTER. I know that is a priority.

Back to the cost issue and possible increases in premium, 9 million participants has to be one of the largest group programs in the country; and I assume it is highly competitive. If—you say we have 270 some different plans.

Mr. GREEN. Different choices, yes.

Mr. PORTER. Different choices. Must be highly competitive. There must be insurance carriers that would like to have this business. We are not having a shortage of companies asking for our business, correct?

Mr. GREEN. No, sir. That's correct.

Mr. PORTER. Any additional questions?

What we will do is take a recess again; and we will be back with the next panel, should be about 20 minutes. Thank you. We are going to combine the panels to help all of your schedules, help expedite it once we come back. Thank you.

[Recess.]

Mr. PORTER. I would like to bring the meeting back to order.

Again, thank you for your patience. Legislative time is one of those very unpredictable items. So, again, thank you very much; and I appreciate being able to combine the panels.

I would like to begin with Mr. Charles Fallis, president of the National Active and Retired Federal Employees Association. You have approximately 5 minutes. Thank you. Welcome.

STATEMENTS OF CHARLES FALLIS, PRESIDENT, NATIONAL ACTIVE AND RETIRED FEDERAL EMPLOYEES ASSOCIATION; COLLEEN KELLEY, NATIONAL PRESIDENT, NATIONAL TREASURY EMPLOYEES UNION; JACQUELINE SIMON, DIRECTOR OF PUBLIC POLICY, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES; ARCHELLE GEORGIOU, M.D., EXECUTIVE VICE PRESIDENT, STRATEGIC RELATIONS, SPECIALIZED CARE SERVICES, UNITEDHEALTH GROUP; STEPHEN W. GAMMARINO, SENIOR VICE PRESIDENT, NATIONAL PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION; AND JOE WITKOWSKI, VICE PRESIDENT, GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION, INC.

STATEMENT OF CHARLES FALLIS

Mr. FALLIS. Thank you Mr. Chairman. I appreciate the opportunity to be here today and to testify on the H.R. 4859 legislation that would implement electronic health records within the Federal Employees Health Benefits Program.

NARFE appreciates your commitment to involve us in the development of H.R. 4859, and we thank you for your willingness to meet with us in an open exchange of ideas looking toward improvement of the legislation.

NARFE recognizes that there are medical benefits stemming from the adoption of HIT; and we believe greater coordination of individual medical records for use by providers could save lives, improve efficiency, and help control health care costs.

NARFE is also supportive of the legislation's commitment to protect individual privacy. Protection of personal medical information is an extremely critical issue for our members, so we are pleased that the bill assures full compliance with HIPPA.

NARFE also supports this bill's provision for voluntary participation. We are confident that many Federal workers and their annuitants will want to build their own electronic records in order to maximize their health care. We are pleased that the creation of such records will be initiated only at the enrollee's request.

While savings may well result from this change, the up-front costs will be significant. The fund's startup of phases I and II of the record system, H.R. 4859, directs OPM to utilize the unused portion of the 1 percent fee the agency receives from FEHBP contributions to cover their administrative cost of managing the plan.

Heretofore, this administrative fee has always been used for its intended purpose, and any remaining or unused balances have been allocated to contingency reserves established for the health insurance plans. Tapping into those contingency reserves to satisfy additional program spending on HIT would represent a significant and unwelcome departure from OPM's past practice in the administration of the plan.

The precedent of using the fee for other than FEHBP administration, including spending for HIT, could create pressure to increase the fee and thus increase enrollee premiums to cover any number of nonadministrative costs. NARFE believes that, to the extent possible, it is essential to maintain the current framework to ensure adequate contingency reserves which help to ensure that premiums are predictable and affordable.

This is especially important at a time of escalating health care costs, coupled with a graying work force and with almost half of the health plan composed of annuitants who have not yet been given the privilege of paying their health care premiums with pretax dollars.

Chairman Porter, we understand and appreciate your willingness to remove from the bill provisions accessing the OPM administrative fee.

While statutory language included in the bill prohibits HIT costs from being taken into account in future FEHB contract negotiations, HIT spending, as currently described in the bill, could nonetheless directly result in higher premiums, which would be opposed strongly by our members.

NARFE is also grateful for your active consideration of adding a provision to the bill that would enable all plan participants, including those who aren't computer savvy, to establish electronic health records. NARFE is concerned that those who don't have access to an Internet portal might not be able to input the necessary data to establish their electronic health records. NARFE suggests incorporating a new language—or incorporating new language into H.R. 4859 to clarify that such individuals could access their electronic health records through a call center where information could be added or checked for accuracy.

Finally, Mr. Chairman, I pledge to you that NARFE will work with you to successfully implement electronic health records within FEHBP and that together I hope that we can work together to address the outstanding issues that I have identified and others have identified today.

I want to thank you for the invitation to share our views and to thank you for your able leadership of the subcommittee. Thank you, sir.

Mr. PORTER. Thank you very much for your testimony. I appreciate your comments and appreciate working with you on the bill. Your comments have made a substantial difference. So thank you very much.

[The prepared statement of Mr. Fallis follows:]

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STATEMENT BY
CHARLES L. FALLIS
PRESIDENT
NATIONAL ACTIVE AND RETIRED FEDERAL EMPLOYEES

TO THE SUBCOMMITTEE ON THE FEDERAL WORKFORCE AND AGENCY ORGANIZATION
COMMITTEE ON
GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES

HEARING ON
H.R. 4859, HEALTHIER FEDS AND FAMILIES: INTRODUCING INFORMATION TECHNOLOGY INTO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM, PART II.

JUNE 13, 2006

Mr. Chairman and members of the Committee, I am Charles L. Fallis, President of NARFE, the National Active and Retired Federal Employees Association. I appreciate the opportunity to express our views on the "Federal Family Health Information Technology Act of 2006", legislation to implement a system of electronic health records within the Federal Employees Health Benefits Program (FEHBP). On behalf of the nearly nine million federal annuitants, workers and their families who participate in FEHBP, we applaud your efforts to ensure that this program retains its high standards of quality and medical coverage. The FEHBP helps assure a healthy federal workforce and constitutes an essential part of federal retirees' and survivors' earned compensation. FEHBP is also a major component of the federal government's role as an employer in the recruitment and the retention of its employees.

NARFE sincerely appreciates your commitment to involve us in the development of H.R. 4859 and the entire health information technology (HIT) process. We thank you and your staff for your willingness to meet with us in an open exchange of ideas toward improvement of the legislation. NARFE recognizes that there are medical benefits stemming from the adoption of HIT, and we believe greater coordination of an individual's medical records for use by providers could save lives, improve efficiency in the overall health care system, and help control health care costs. As president of an organization that represents thousands upon thousands of retirees, I can easily envision a scenario where use of electronic health records could prevent duplication of costly diagnostic measures and perhaps even save the life of an ailing and unconscious annuitant who arrives at a hospital outside his hometown. By being able to access this individual's medical records, the emergency room personnel would be fully informed of his prior diagnoses and current treatment plans, and could provide the appropriate care, without having to "guess" at the illness or risking his exposure to any possible allergies.

NARFE is also supportive of the legislation's commitment to the protection of individual privacy. Ensuring the protection of medical information is critical for our members and for all FEHBP participants. In light of disturbing lapses by the federal government in maintaining individuals' personal information, including the recent debacle at the Department of Veterans' Affairs (DVA) and an earlier theft of TRICARE participants' records from Department of Defense (DOD) contractors, NARFE remains very concerned about the handling and storage of federal employees' and retirees' medical records. We are pleased the bill assures full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and we pledge to be engaged on overall privacy issues related to the use of HIT that is being worked on by both the Department of Health and Human Services (HHS), as well as by the congressional committees that have jurisdiction of these larger health care issues. Electronic health records within FEHBP should never be made available to certain entities, including pharmaceutical companies, for marketing purposes; fundraising organizations that could target enrollees because of a particular health condition; employers, including the federal government, except for purposes of the Federal Employees Compensation Act; and lenders, especially as insurance carriers expand into the banking business. In addition, we believe individuals must retain full control over the disclosure of their electronic health records to providers and other health care facilities.

In addition, NARFE is supportive of the legislation's construction of a voluntary process for FEHBP enrollees to participate in HIT. We are confident that many federal workers and annuitants will want to build an electronic record in order to maximize their health care. We are pleased that the genesis of an electronic health record is only at an enrollee's request. NARFE believes that those individuals who want to establish an electronic health record should be able to

do so easily. And, we believe that those who are not interested in taking part should not be required to take any action.

While savings may well result from this change in how we do business, the upfront cost for establishing electronic records will have to be paid for. H.R. 4859 as introduced directs the Office of Personnel Management (OPM) to apply the unused portion of FEHBP contributions, the one percent administrative fee for OPM's administrative cost in managing FEHBP, to fund phases I and II of the electronic health record system. Since FEHBP's inception, the one percent administrative fee has always been employed for its intended purposes, namely covering OPM's personnel costs and expenses to administer FEHBP with any balance being allocated to contingency reserves established for the health insurance plans. Tapping into the so-called "unused" portion of these FEHBP contributions in order to satisfy additional program spending on HIT would represent an unacceptable departure from OPM's and its predecessor agency, the U.S. Civil Service Commission's, past administration of the FEHBP. As stakeholders in the FEHBP, NARFE believes that the one percent administrative fee should continue to be used for its intended purpose.

The precedent of using the administrative fee for other than program administration, including HIT, could create pressure to increase that fee and increase enrollee premiums to cover any number of non-administrative costs. Going down this road would be both unwise and unnecessary. Moreover, at a time of escalating health care costs, coupled with a graying federal workforce and with almost half of the FEHBP composed of annuitants, NARFE believes it is essential to maintain the current framework to ensure adequate contingency reserve funds which help to ensure that premiums are predictable and affordable to the extent possible.

In conversations with committee staff in response to these concerns, we understand that you, Chairman Porter, are willing to remove from the bill provisions accessing the one percent administrative fee from the legislation. We appreciate your willingness to address this concern. Our further concern, however, is that despite statutory language included to prohibit HIT costs from being taken into account in premium and benefit contract negotiations, HIT spending needed to implement H.R. 4859 could directly result in higher FEHBP premiums, absent a dedicated source of funding. In recent years, both federal workers and annuitants have experienced consistent double digit premium increases, and NARFE members are wary of any item that could cause their rates to soar even higher.

NARFE is also grateful to your committee staff for their active consideration of additional language that would enable ALL FEHBP participants to establish electronic health records, including those who might not be "computer savvy". While many federal employees operate computers on a daily basis, there are many older annuitants who either do not have access to a computer to input data into a web-based portal, or who are lacking computer literacy. Under current HIPAA law, individuals are granted full access to all of their medical records by requesting hard copies of such records. NARFE is concerned that an individual who does not have access to an internet-portal might not be able to input the necessary data to establish an electronic health record. In order to assure absolute access to electronic health records, NARFE suggests incorporating new language in H. R. 4859 that clarifies that individuals could access their electronic health record through a call center where information could be added and/or checked for accuracy. These additions will guarantee that all interested individuals can take advantage of the benefits stemming from HIT.

Mr. Chairman, I pledge to you that NARFE will work with you and your staff to successfully implement electronic health records within FEHBP. We certainly recognize the potential that exists for new technology to revolutionize the health care system and we share your eagerness to have FEHBP play a part in the promotion of HIT. Thank you for the invitation to share our views here today, and thank you for your able leadership of the Subcommittee.

Mr. PORTER. Is there anyone here that has a time constraint or who has the worst time constraint? Is there planes to catch or anything that we can help you with at this point?

We have one at 6:30.

We are going to be here until probably midnight so—no problem.

Next, Colleen Kelley. She is the national president, National Treasury Employees Union. It is always a pleasure to see you. Thank you for being here.

STATEMENT OF COLLEEN KELLEY

Ms. KELLEY. Thank you, Chairman Porter, Congressman Cummings. It is truly a pleasure for me to have the opportunity to testify on behalf of the 150,000 employees represented by NTEU.

Federal employees and retirees are very concerned about the quality and the cost of the health insurance that they received through the FEHBP. National Treasury Employees Union has been involved in several initiatives to improve the program, including legislation to hold down the cost for enrollees.

At a time when Federal pay rates lag behind the private sector and attempts are being made to reduce employee rates in several departments and workers are being subjected to determined efforts to contract out their work, health insurance becomes one of the most attractive features to both recruit and retain the best and the brightest to the Federal service. A decline in the quality or an increase in the cost of health insurance may be the last straw for a productive employee or applicant.

FEHBP must be modern, efficient and well-functioning. It must embrace what is best in emerging technology to better serve its beneficiaries. The Federal Family Health Information Technology Act, properly implemented, can serve that goal. Requiring FEHBP carriers to create electronic health records available to individual enrollees, these records have the potential to provide important benefits to the enrollees, including better coordination of medical records, easier access to those records and, as you have noted, could save lives.

National Treasury Employees Union agrees with the important and worthy goals of this legislation.

Having said that, I would like to outline a few concerns and propose some improvements that we feel would be beneficial to this legislation; and they fall into four categories: privacy, oversight, access and funding.

On the privacy issue, from my discussions with NTEU members, privacy is a significant concern. Most important is the need to protect Federal employees from any inappropriate access to their personal medical records. In particular, their employer should not have that access. Further, this information needs to be kept from disclosure to sales and marketing entities, such as pharmaceutical vendors and others, not just written prohibitions of such disclosures but systems that really protect the privacy with rigorous enforcement. FEHBP enrollees must have recourse to remedies when their privacy rights are violated.

The opt-in provision in the legislation helps to make sure that those in FEHBP who have privacy concerns are not forced into participating in a program they are not comfortable with.

I agree with former House Speaker Newt Gingrich who testified before the subcommittee recently when he said it can be expected that substantial numbers of FEHBP enrollees would elect to opt in. I agree with that. But enrollees must have that choice, and NTEU strongly supports the opt-in provision of this legislation.

On oversight, NTEU believes that, to ensure proper privacy standards, OPM and HHS must, in a formal way, engage Federal employee and retiree representatives. This legislation should require HHS's Office of the National Coordinator for Health IT to meet periodically with Federal employee and retiree organizations to consult with them, to provide them with all information needed to make a thoughtful review of these matters, including the number and nature of all privacy complaints made by FEHBP participants, and to give great weight to any recommendations made by these organizations.

The chief privacy officers at both OPM and HHS will play key roles in protecting privacy. These positions need to be made full-time positions. They also need their authority enhanced by having the power to undertake investigations and to issue reports as they deem necessary, as well as having subpoena power. In order to ensure the independence and the integrity of the privacy officer, any removal or transfer should require a notification to both Houses of Congress.

I believe it is also important that HHS and OPM both report back on a regular basis to this subcommittee as well and that the subcommittee perform proper oversight of FEHBP privacy issues. That way, there will be ongoing congressional review; and any laxness or shortcomings either in enforcement or legislative authority can be resolved.

On the access issue, improved access by enrollees to personal medical information is obviously an important feature of this legislation. As already noted, electronic Web-based access is the means most enrollees will utilize. However, as you, Chairman Porter, also already recognized, some of enrollees need access other than through the Web portal. Provisions need to be made so that they have the opportunity to access their medical records as well.

On the funding issue, the passage of this legislation will put the Nation's largest employee health benefits program behind the development of medical IT. In the long run, both Federal and private sector employees will benefit. Therefore, it would be unfair for FEHBP participants to bear even a short-term premium increase for what is a social benefit.

I note that the bill prohibits increase in FEHBP premiums. In this provision, strict enforcement will be a key issue. Given the legislation's potential benefit to the private sector as well as the Federal sector, it would seem proper and reasonable that costs associated with short-term development be provided for by an appropriation from general revenue.

On the funding issue language, NTEU very much appreciates your decision and your commitment to remove the language prior to markup that would have allowed the unused portion of the 1 percent administrative fee to be made available to fund this system.

You and this subcommittee and your staff have been very open to listening to NTEU's concerns on this issue, and we very much appreciate it and look forward to working with you on the development of an electronic health record system that does protect the privacy and promote the health care efficiency for Federal employees.

I would be happy to answer any questions you have. Thank you.

Mr. PORTER. Thank you, Ms. Kelley.

I said it to Mr. Fallis. Your comments have played a big role, both of you; and I appreciate working with you. These adjustments have come about after we have had our numerous meetings and discussions. So thank you for your input, and I certainly agree with your insights as to those areas. Plus, this could well be a landmark piece of legislation in changing health care not only for Federal employees but for the country. I am very pleased to have your help, and I really appreciate it. Thank you.

[The prepared statement of Ms. Kelley follows:]

NTEU
The National Treasury Employees Union

STATEMENT OF COLLEEN M. KELLEY
NATIONAL PRESIDENT
NATIONAL TREASURY EMPLOYEES UNION

ON

FEDERAL FAMILY HEALTH INFORMATION TECHNOLOGY ACT

SUBMITTED TO

SUBCOMMITTEE ON THE FEDERAL WORKFORCE
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES
JUNE 13, 2006

STATEMENT OF COLLEEN M. KELLEY, NATIONAL PRESIDENT

NATIONAL TREASURY EMPLOYEES UNION

**TO THE SUBCOMITTEE ON THE FEDERAL WORKFORCE,
COMMITTEE ON GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES**

JUNE 13, 2006

Chairman Porter, Ranking Member Davis, and members of the House Subcommittee on the Federal Workforce and Agency Organization, my name is Colleen M. Kelley and I am National President of the National Treasury Employees Union (NTEU). I am always grateful to come before this subcommittee and to have the opportunity to present this testimony today on behalf of the members of NTEU.

Federal employees and retirees are highly concerned about the quality and cost of the health insurance they receive through the Federal Employees Health Benefit Program (FEHPB). NTEU has been involved in several initiatives towards that end, including legislation to control costs for employees and retirees by increasing the employer contribution to FEHBP premiums.

At a time when federal pay rates lag significantly behind the private sector, attempts are being made to reduce employee rights in several departments and workers are subjected to ham-fisted schemes to contract out government work, health insurance becomes one of the most attractive features to recruit and retain the best employees. A decline in quality or an increase in cost of health insurance may be the last straw for a productive employee or applicant.

FEHBP must be kept modern, efficient, and well-functioning. It must embrace what is best in emerging technology so to better serve its beneficiaries. The Federal

Family Health Information Technology Act (HR 4859), properly implemented, can serve that goal. It has the potential to improve the quality of medical care, reduce errors and over time, control costs. HR 4859 would require Federal Employee Health Benefit Program (FEHBP) carriers to create electronic health records available to individual enrollees. These records have the potential of providing important benefits to beneficiaries. It will assist with better coordination of medical records, allow easier access to these records and, I believe, will save lives. FEHBP offers participants one of the widest varieties of providers of any health insurance system in the nation. The result is that participants can and often do move from plan to plan for reasons of cost, preference, relocation or other factors. With every change, there is a chance of an incomplete transfer of records.

Moreover, at some point in many peoples' lives, they have a period of extended sickness that may include multiple conditions, the use of different specialists and various medicines. Further, there may be difficulties in communicating their health situation and status to their attending doctor. This presents difficulties to the treating physician as well as the potential for improper treatment. The same is true in emergency room situations where patients can arrive unaccompanied and unconscious. By addressing this situation, electronic medical records can provide an important service to avoid some of the problems of such a situation.

Even for healthy persons, sudden tragedies like Hurricane Katrina can result in the loss of paper medical records and the removal of individuals from their family doctor and regular hospital as well as their own personal records. The bottom line is that no one benefits from medical records and important health information being kept on paper records, uncentralized and unaccessible when needed.

NTEU understands the important and worthy goals and objectives of this legislation. Having said that, I would like to outline some concerns and improvements we feel would be beneficial to this legislation.

PRIVACY

One of the most serious issues that must be considered with regard to this legislation is privacy. From my own discussions with NTEU members, I can tell you privacy is a significant concern. The development of privacy standards are essential prior to the implementation of this legislation. I cannot say that NTEU is entirely confident that this legislation in its current form fully protects participant privacy.

An "opt-in" provision helps to make sure that those FEHBP participants who have privacy concerns are not forced into participating in a program they are not comfortable with. I agree with former House Speaker Newt Gingrich who testified before this subcommittee recently that it can be expected that substantial numbers of FEHBP enrollees would elect to opt-in. At the same time, the rights of those who feel differently are protected and they maintain the option to opt in at a future time.

The recent situation at the VA shows that the status quo is not working. In order to ensure proper privacy standards, the Office of Personnel Management (OPM) and the Department of Health and Human Services (HHS) must, in a formal way, engage in on-going consultations with federal employee and retiree representatives. This legislation should require HHS's Office of the National Coordinator for Health IT (ONC) to meet periodically with federal employee and retiree organizations, to consult with them, to provide them with all information needed to make a thoughtful review of these matters including the number and nature of all privacy complaints made by FEHBP participants towards carriers, and to give great weight to any recommendations made by these organizations. The chief privacy officer at both OPM and HHS should interact with these organizations. Currently, the agency privacy officers are not full time positions but simply duties added to an existing position. At HHS and OPM, these should be made full time positions where the officer's exclusive duties are protecting privacy rights. These positions also need their authority enhanced. The privacy officer should have the authority to undertake investigations and issue reports that are deemed

necessary by the privacy officer as well as subpoena power. Further, in order to insure the independence and integrity of the privacy officer, any removal or transfer should require notification to both houses of Congress.

A full review of the Health Information Portability and Accountability Act (HIPAA) is needed to ensure that the privacy protections it mandates are applicable and adequate to provide protection to FEHBP enrollees under the proposed system. In addition to other privacy concerns, federal employees need to be protected from their employer having any access to their personal medical records.

In addition to proper standards, there needs to be the will to enforce whatever standards are developed. Mr. Chairman, I was very disturbed by recent news reports that the Department of Health and Human Services was not rigorously enforcing existing privacy standards. The degree of complacency in guarding privacy directly relates to the willingness of HHS to enforce law and regulation. Warnings, wrist-slaps and fines of as little as $100 to wrongdoers is not enough. Enforcing agencies need to take seriously their duties and not be afraid to punish those who violate privacy protections. Strict enforcement and firm punishment will result in proper compliance. FEHBP enrollees must have recourse to remedies when their privacy rights are violated.

I believe it is also important that ONC and OPM both report back on a regular basis to this subcommittee as well and that the subcommittee perform proper oversight of FEHBP privacy issues. That way, there will be on-going congressional review and any laxness or shortcomings either in enforcement or legislative authority can be resolved.

ACCESS

Improved access by enrollees to their personal medical records is an important feature of this legislation. Electronic, web-based access is the means which most FEHBP enrollees will utilize. However, some enrollees, particularly retired federal workers and

their survivors, do not have access to a web-based portal or do not have the computer skills needed. Provisions need to be made so that they have the opportunity to access their medical records as well.

COSTS

Passage of this legislation will put the nation's largest employee health benefits program behind the development of medical IT. This will not only promote medical IT with FEHBP carriers but will have a society wide impact. FEHBP participation will give medical IT the critical mass it needs to work effectively. In the long run, both the federal and private sector should benefit. Therefore, it would be unfair for FEHBP participants to bear even a short term premium increase for what is a social benefit. I note that the bill prohibits increases in FEHBP premiums to pay for medical IT. NTEU commends you, Mr. Chairman, and Representative Clay for the inclusion of this important provision. This provision's strict enforcement will be the key issue. Given this legislation's potential benefit to all of society – private sector as well as the federal sector – it would seem proper and reasonable to NTEU that costs associated with short term development of medical IT in FEHBP be provided for by an appropriation from general revenue.

The legislation does establish a trust fund at the Office of Personnel Management to accept private contributions that can be used to encourage providers to implement provider-based electronic health care records. While NTEU would prefer simply a financing of the costs by appropriations, the trust fund, with proper safeguards, can also be a means of providing financing and preventing any FEHBP premium increases.

As introduced, this legislation did allow the unused portion of FEHBP's one percent administrative fee to be made available to fund the electronic health record system. NTEU and other organizations had reservations about this method of financing, as the unused portion of the administrative fees is deposited to the contingency reserve fund. Our concern was that paying for these costs from the administrative fee reduces the

amount available for the contingency fund and thereby, in the end, reduces that fund. You and your staff have been very open to listening to NTEU's concerns here. We understand it is your intention to remove this from this legislation, which NTEU deeply appreciates this.

Mr. Chairman, as always, I am honored to appear before this important subcommittee. Again, I commend you for taking the initiative on this matter. While I have outlined some concerns and proposed improvements to this legislation, I look forward to working with you on the development of electronic health records that protect privacy and promote health care efficiency. I would be happy to answer any questions that you or other members of the subcommittee may have. Thank you.

Mr. PORTER. Next, we have Jacqueline Simon, Director of Public Policy, American Federation of Public Employees. Thank you.

STATEMENT OF JACQUELINE SIMON

Ms. SIMON. Mr. Chairman, I want to thank you for your personal attention to this legislation and the access that you provided AFGE during your deliberations. We know that the plan is extremely well intentioned.

My testimony, however, will focus on the many questions Federal employees have regarding privacy, costs, accuracy, access and the potential difficulties that may emerge from the implementation and maintenance of electronic health records in the context of FEHBP's current structure and regulatory framework.

The No. 1 concern is privacy and security, which I address at length in my written testimony. There is enormous concern among Federal employees that EHRs will not be secure from either loss or unauthorized access, as the recent theft of data from an employee from the Department of Veterans Affairs attests.

Although the privacy rule acquired under HIPPA requires medical professionals to limit disclosure of medical information to the minimum necessary and this rule will be applicable to Federal EHRs and FEHBP, the rule is not absolute. In fact, the regulatory regime for protecting privacy of health information is quite complex and fragmented throughout the country. And even if HIPPA and its regulations were adequate, the current reluctance to enforce Federal regulations makes the bill's conformance with HIPPA almost an irrelevancy.

The Washington Post reported last week that in the 3 years since HIPPA's enactment no fines have been imposed, even though more than 19,000 grievances have been filed. The grievances included allegations that, "personal medical details were wrongly revealed, information was poorly protected, more details were disclosed than necessary, proper authorization was not obtained and patients were frustrated getting their own records."

Although the insurance companies, hospitals, health plans and doctors interviewed for the article were reported to be quite satisfied with the lax enforcement, patients and patient advocates were not. Especially troubling for Federal employees, the representative from HHS whose office is responsible for enforcing the law was quoted saying that, "challenges with our resources," was part of the explanation for why more has not been done to enforce the law.

Federal employees are more intimately aware than anyone that inadequate funding for agency staffing and political bias have made regulatory enforcement a low priority. They will not find credible promises that OPM will enforce HIPPA-like privacy protections, and they will not find credible assurances that the data or the program will be implemented in ways that serve their interests.

Privacy is such an enormous concern because a health record reveals some of the most intimate and personal aspects of one's life. Medical records include the details of family history, genetics, diseases and treatments, illegal drug use and sexual orientations and practices. Subjective remarks about a patient's demeanor and character and mental states are also sometimes part of a record. The bill does not address how variations in business policies, State laws

that affect privacy and security practices, including those related to HIPPA, and other challenges to health information exchange could result in the mishandling or misinterpretation of patient health records, even assuming that HIPPA protections were enforced.

If the government cannot guarantee generally impregnable firewalls to protect privacy and control access, then no Federal employee's health information should be placed in an electronic record without his or her affirmative permission, permission that must be able to be withdrawn and given entirely at will.

Another troubling aspect of the bill is the assumption that its adoption will result in significant savings, the EHRs will pay for themselves. While there may be some clinical savings and gains from greater physician productivity as a result of using EHRs, there is every reason to believe that most or all of these savings will be offset by administrative costs. The added administrative costs will be real and the savings are only hoped-for projections.

Even if the money is saved by better coordination of care or use of preventive services, forcing every practice that participates in an FEHBP plan to submit yet another set of medical data will be extremely costly.

The startup costs to fund EHRs in the Federal Government will be considerable. AFGE strongly opposes the use of the FEHBP reserves for this purpose, and we are glad to hear that you have agreed to delete this provision from the bill.

We believe this program should be started as a pilot or a demonstration project within FEHBP and be open to a small population of volunteers. If the projections of savings are realistic, insurance companies should be eager to participate and should be willing to subject themselves to the government cost accounting standards in order to prove that the savings are real.

Once the pilot has had a sufficient period of time to allow objective evaluation of its costs and benefits, the decision can be made whether to expand it. If it is as successful as the bill's advocates believe it will be, it is likely that both insurance companies and Federal employees will be comfortable participating.

This concludes my statement. I will be happy to answer any questions you may have.

Mr. PORTER. Thank you very much for your testimony, Ms. Simon. I appreciate you telling us what you think.

Ms. SIMON. Thank you for the opportunity, sir.

Mr. PORTER. No problem. We appreciate it.

I, too share, the majority of your concerns; and that is why we have spent a lot of time and will continue to do so making sure we get it right.

You know, I have met with—and if this subcommittee would allow—I met with a veteran the other day who is in the Veterans Administration under its health care plan. He was about 80 years old, sitting in my office. He was a disabled American vet, had a substantial handicap and a friend for many years. He spent a lot of time talking about the advantages of the veterans' health care system and access to his health care records and being able to communicate with his doctor and being able to communicate via technology.

Just know that there are areas of concern, and I share with you. But there is also great successes, and we want to make sure we can emulate those. So, again, your points are well taken; and we appreciate your testimony.

Ms. SIMON. Thank you, sir.

As you probably know, AFGE represents most of the employees of the Veterans Administration; and they take great pride in the health care they provide our veterans. I am really glad to heard that. Thank you.

Mr. PORTER. Thank you very much.

[The prepared statement of Ms. Simon follows:]

Congressional Testimony

STATEMENT BY

JACQUELINE SIMON
PUBLIC POLICY DIRECTOR
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTEE ON FEDERAL WORKFORCE AND AGENCY ORGANIZATION

HOUSE COMMITTEE ON GOVERNMENT REFORM

REGARDING

THE FEDERAL FAMILY HEALTH INFORMATION TECHNOLOGY ACT OF 2006 (H.R. 4859)

ON

JUNE 13, 2006

I. INTRODUCTION

My name is Jacqueline Simon, and I am the Public Policy Director of the American Federation of Government Employees (AFGE), AFL-CIO. On behalf of the 600,000 federal employees represented by AFGE who serve the American people across the nation and around the world, I thank you for the opportunity to testify on the Federal Family Health Information Technology Act of 2006 (H.R. 4859).

At the outset, Mr. Chairman, let me thank you for your personal attention to this legislation and the access that you have provided to AFGE during your deliberations. We know that the plan is well-intentioned.

The Federal Family Health Information Technology Act of 2006 proposes to allow that every participant of the Federal Employees Health Benefits Program (FEHBP) maintain a personal electronic health record (EHR). It would also require every insurance company and health care provider to create and maintain electronic records for each individual covered by an FEHBP plan. The rationale for the legislation is to overcome the costs and problems that derive from the fact that current methods of compiling and tracking medical data are so fragmented that they give rise to medical errors, duplicative testing, and incomplete medical histories. There is no question that these problems have the potential to adversely affect the quality of health care, and in some instances may compromise patient safety.[1] Another impetus is to respond to the frustrations and unnecessary costs borne by those who, because they must see multiple doctors, are sometimes forced to repeat tests and procedures because of lost or misplaced records. Requiring electronic medical records under the new bill is an attempt to address these issues and ultimately improve health care delivery for patients.

Although health information technology may assist physicians and other medical professionals in reducing medical errors, my testimony will focus on the many questions federal employees have regarding privacy, costs, accuracy, access, and the potential difficulties that may emerge from the implementation and maintenance of electronic health records in the context of FEHBP's current structure and regulatory framework.

II. CONCERNS

While supporters of the bill have maintained their belief that using electronic technology to compile and transfer medical data could prevent "tens of thousands of patients" from dying every year due to medical errors, it seems premature to make such claims without first testing the advantages and disadvantages of this new initiative in a pilot project within FEHBP. There is

[1] GAO-06-346T, "Health Information Technology: HHS is Continuing Efforts to Define a National Strategy" (March 15, 2006).

precedent for making dubious claims on behalf of FEHBP in the context of national health policy. To the extent that FEHBP is used as a model for other federal health insurance programs, it is important that great care be taken to make sure that the terms for adoption of electronic technology is accomplished in a way that justifies its costs and minimizes its risks.

AFGE cannot assume that using EHRs will be a "cure-all" to the countless problems in American health care generally or even FEHBP specifically. According to the Institute of Medicine, the federal government has a central role in shaping nearly all aspects of the health care sector as a regulator, purchaser, health care provider, and sponsor of research, education, and training.[2] Given the federal government's significant influence in the health care industry, it is crucial that it utilize adequate safeguards and always keep the best interest of the patient as the primary focus in its policies, particularly in the context of implementing this proposed legislation. Because of the political prominence of FEHBP, failure to take these precautions could set dangerous precedents that might affect health care delivery not just for federal employees, retirees, and their dependents, but for the entire country as well.

A. Privacy: Promises Are Not Enough

Although physicians have always been bound by a code of conduct requiring that they protect the privacy of their patients, in recent years health information has come into use by many organizations and individuals who are not subject to medical ethics codes.[3] The ubiquitous use of computers has made access to confidential medical records much easier, and much more vulnerable to exploitation. However much potential digitizing federal employee health records has to improve health care by avoiding errors and helping providers base treatment on more complete information, health care automation could create problems for the patient that extend far beyond the hospital or clinic. There is legitimate concern that electronic health records will not be secure from either loss or unauthorized access, as the recent theft of data from an employee of the Department of Veterans Affairs attests. A recent survey of more than 1,000 consumers found that 44% rank overcoming privacy and security issues as the "top challenge" in implementing EHRs.[4] Yet, 86% of respondents are "somewhat or very concerned about the health industry's ability to protect the privacy of personal health information in deploying EHRs."[5]

Although the "privacy rule," established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires medical professionals to make

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[2] GAO-06-346T, "Health Information Technology: HHS is Continuing Efforts to Define a National Strategy" (March 15, 2006).
[3] www.epic.org/privacy/medical
[4] Health Industry Insights citing *Consumer Attitudes Toward EMRs, EHRs and the Privacy of Health Information.* (Marc Holland)
[5] Health Industry Insights citing *Consumer Attitudes Toward EMRs, EHRs and the Privacy of Health Information.* (Marc Holland)

reasonable efforts to limit the disclosure of medical information to the "minimum necessary, " this rule is not absolute. While insurance companies and providers are well aware of their duties under HIPAA, it is questionable if all medical personnel understand the various restrictions surrounding "medical privacy" and how to treat confidential data.[6] As the Electronic Privacy Information Center has correctly stated, "the regulatory regime for protecting privacy of health information is complex and fragmented."[7] Although there is a federal mandate on protecting health information, there are also existing state laws which protect the confidentiality of patient information to varying degrees as well.[8] There are also protections that apply only to specific medical conditions or types of information, such as information related to HIV/AIDS or substance abuse treatment.[9] Some medical professionals may have already been mystified by the complexity of HIPAA alone. Navigating state law and other regulations in conjunction with HIPAA seems to further obscure what is truly considered private.

Even if HIPAA and its regulations were adequate the current reluctance to enforce federal regulations makes the bill's conformance with HIPAA almost an irrelevancy. *The Washington Post* reported last week that in the three years since HIPAA's enactment, no fines have been imposed even though 19,420 grievances have been filed. The grievances included allegations that "personal medical details were wrongly revealed, information was poorly protected, more details were disclosed than necessary, proper authorization was not obtained, (and), patients were frustrated getting their own records." Although insurance companies, hospitals, health plans, and doctors were reported to be quite satisfied with the lax enforcement, patients and patient advocates were not. Especially troubling for federal employees, the representative from the Department of Health and Human Services (HHS) whose office is responsible for enforcing the law is quoted saying that "challenges with our resources investing compliance" was part of the explanation for why more has not been done to enforce privacy complaints.

Federal employees are more intimately aware than anyone that inadequate funding for agency staffing and political bias have made carrying out regulatory enforcement a low priority. They will not find credible promises that the Office of Personnel Management (OPM) will enforce HIPAA-like privacy protections, and they will not find credible assurances that the data or the program will be implemented in ways that serve their interests.

Privacy is such an enormous concern because one's health record can often reveal some of the most intimate and personal aspects of a federal employee's life. Medical records include the details of family history, genetic testing,

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[6] http://www.hhs.gov/ocr/hipaa/consumer_rights.pdf
[7] www.epic.org/privacy/medical
[8] www.epic.org/privacy/medical
[9] www.epic.org/privacy/medical

diseases and treatments, illegal drug use, sexual orientation and practices, and testing for sexually transmitted diseases. Subjective remarks about a patient's demeanor, character, and mental state are sometimes a part of the record as well.[10] The proposed legislation does not address how variations in business policies, state laws that affect privacy and security practices, including those related to HIPAA, and other challenges to health information exchange could result in the mishandling or misinterpretation of patient health records—even assuming that HIPAA protections were enforced.

While the system may be designed to facilitate collaboration and improve medical care, the legislation establishes no safeguard to ensure that individual confidentiality will not be compromised. There are no direct restraints on who has access to a patient's health and/or medical information, what information from a patient's health records will and will not be available for viewing, or if there will be an electronic paper trail created by anyone who looks at the records. If the federal government cannot commit to genuinely impregnable firewalls to protect privacy and control access, then no federal employee's health information should be placed in an electronic record without his or her affirmative permission, permission that must be able to be withdrawn and given entirely at will.

B. Costs: Who Will Pay?

One of the most troubling aspects of the proposed Federal Family Health Information Technology Act of 2006 is its advocates' insistence that the adoption of electronic health records will result in significant health care cost savings, and that these savings will be passed on to either agencies, enrollees, or both. While there might be some clinical savings and gains from greater physician productivity as a result of using EHRs, there is every reason to believe that most or all of these savings will be off-set by higher administrative costs. *The added administrative costs are real and the savings are only hoped-for projections of future savings.* Even if money is saved by better coordination of care and integration of recommendations for preventive services that will help to avoid or greatly diminish the costly deterioration in a patient's condition, forcing every practice to submit yet another set of medical data will be extremely costly. Direct providers of medical care already have to collect their own records (as required under standard medical practice protocols and malpractice insurance requirements) and submit bills to insurers and/or patients. This legislation will essentially force them to complete yet another reporting requirement. Although there are provisions for temporary financial "incentives" or subsidies to providers, what happens when the period for these payments expires? Small medical practices will become so overwhelmed, physically and financially, by having to duplicate their efforts to document a patient's health and medical history, that the

[10] "Protecting Privacy in Computerized Medical Information," Digest of OTA Report (September 1993).

end result might cause them to drop their insurance carriers simply because they will not tolerate any more paperwork. More than 67% of consumers who were surveyed agree that electronic medical records will not "materially reduce" the cost of health care, even if it favorably impacts the delivery of care.[11]

While the Christiana Medical Center in Delaware was cited as an example in the previous hearing on this legislation to advertise the cost-saving results that health information technology can produce, it must be recognized as an unusual and special case because just one health plan and one medical center cover a huge percentage of one community's population. A more useful and realistic test of the efficiency and cost-saving potential of EHRs needs to be performed on scattered, small medical practices since they are a far more common phenomenon within FEHBP. Indeed, the largest FEHBP plan, the Blue Cross-Blue Shield Standard Option, includes nationwide networks of hundreds of thousands of providers. Testing cost effectiveness of EHRs on small medical practices will measure the impact of increased administrative costs for developing and maintaining electronic records, as well as the size of start-up costs. In fact, a recent study found that "start-up costs for an electronic health records system cost about $44,000 per physician in small-group practices."[12]

The start-up costs to fund EHRs in the federal government will likely be just as significant, but the government may not be able to finance those costs. The Federal government has chosen to fund the initial phases of implementation by expending the remainder of the one percent of reserves not currently used for other administrative costs by OPM. *AFGE strongly opposes the use of the FEHBP reserves for this purpose.* To propose to use the reserves to fund electronic medical records directly contradicts the pledge to have insurance carriers bear the initial costs of system, as the reserves are paid by agencies and enrollees.

Although OPM claims that this money will be recouped from the savings that the new technology system will bring, there is no empirical evidence to suggest that this program will ever bring any savings, and even if it did, there is nothing to suggest when these savings would begin to accrue.

Finally, AFGE strongly disagrees with the contention that Blue Cross-Blue Shield or any other health insurance carrier will effectively be prevented from passing along the costs of the electronic medical records initiative to plan participants. FEHBP carriers have won a statutory exemption from application of the government's Cost Accounting Standards (CAS) that are applied to other large federal health care contracts.

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[11] Health Industry Insights citing *Consumer Attitudes Toward EMRs, EHRs and the Privacy of Health Information.* (Marc Holland)

[12] **Medscape** citing **The Nation's Health**: "Improved Medical Technology Could Affect Health, Lower Cost," by Kim Krisberg (November 11, 2005).

The government's CAS are designed, among other things, to ensure that contractors appropriately estimate, accumulate and report their contract costs in a consistent manner, as well as allocate the costs that involve their non-government customers. Without the protections afforded by CAS, there is literally no way to ensure that FEHBP's carriers are prevented from assigning the costs associated with carrying out the electronic medical records initiative to the plan participants. At a minimum, it is necessary to remove the exemption from the application of CAS from all FEHBP carriers in order to provide the government with the ability to enforce its promise to federal employees and retirees that the cost of this initiative will not be paid by participants.

C. Opt-Out

Motivating federal employees to participate voluntarily in the use of electronic health records will undoubtedly present a challenge, since many individuals have legitimate apprehensions about the security, effectiveness and usefulness of such a practice. They need only read the newspaper to learn about the government's failure to enforce HIPAA, or the unfortunate theft of millions of veterans' financial and medical information to justify their unease. Forcing an individual to put his or her medical records on-line will foster enormous anger and resentment among federal employees, and leave them feeling as if they are being forced to sacrifice control over the privacy, access, or distribution of their medical records as part of the price of federal employment. They will fear that their records may fall into the hands of current or future employers who could misinterpret information and use it against them without their ever knowing what transpired. They will know that the Administration places a low priority on regulatory enforcement, and they will doubt the efficacy of electronic records as a health care cost reduction tool. Finally, even for those who may be persuaded that there will be a cost or quality of health care rationale for electronic medical records, there will be serious questions about privacy and accuracy.

We believe that this program should be started as a pilot or demonstration project within FEHBP, and be open to a small population of volunteers. If projections of savings are realistic, insurance companies should be eager to participate and should be willing to subject themselves to the government's CAS in order to prove that the savings are real. Once the pilot has had a sufficient period of time to allow objective evaluation of its costs and benefits, the decision can be made whether to expand it. If it is as successful as the bill's advocates believe it will be, it is likely that both insurance companies and federal employees will be comfortable with participating.

D. Efficiency

Providing accurate and comprehensive health care information is critical to the physician-patient relationship and the quality of health care delivery. In some instances, we are persuaded that using EHRs can facilitate progress in this area.

However, there is a great deal of evidence suggesting that the use of electronic medical records can actually cause a breakdown in the communication between physician and patient, and in many instances can disrupt the delivery of efficient and quality health care.

In a study examining the way that physicians use computers to collect and interpret patient health records in the examination room, results showed that technology can be extremely disruptive, causing a great deal of tension between the control of the EHR process and conduct of a medical interview.[13] Physician behavior was described as "pre-occupied," with attention largely focused on the computer monitor and only intermittently on the patient. The patient visits were characterized by "frequent periods of silence," and the use of EHRs often caused a change in the physician's work style from "conversational" to "block" style.[14]

The study further found that this type of verbal distancing from the patient does in fact negatively affect the patient-doctor relationship, particularly in the psychosocial and emotional realm. The doctor's constant attention to the screen seemed to suggest to the patient that his or her issues were unimportant or that there was a lack of interest or unwillingness on the part of the physician to engage in interaction. This often caused the patient to be emotionally unresponsive and avoid full disclosure, which in turn greatly inhibited the doctor's ability to properly diagnose and/or treat that patient.[15]

The observational study also found that while the use of electronic medical records strengthened the physician's ability to gather data, there were other unfortunate effects that EHRs had on patient-centered medical care. The benefit of the physician being able to gather data more efficiently was largely undermined because the physician virtually never shared the screen with patients to review medical information that may have affected his or her health (i.e. laboratory test results, patient progress in disease management, understanding of a disease or a specific treatment.)[16] Thus, errors in transmission of information compromised the accuracy of the information in the EHR.

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[13] Patient Education and Counseling 61 (2006) 134-141: "Electronic Medical Record Use and Physician-Patient communication: An Observational study of Israeli primary care encounters," by Ruth Stashefsy Margalit, Debra Roter, Mary Ann Dunevant, Susan Larson, Shmuel Reis.
[14] Patient Education and Counseling 61 (2006) 134-141: "Electronic Medical Record Use and Physician-Patient communication: An Observational study of Israeli primary care encounters," by Ruth Stashefsy Margalit, Debra Roter, Mary Ann Dunevant, Susan Larson, Shmuel Reis.
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It must be acknowledged that the amount of information that a physician has about a patient at the point of care does not impact the quality of care that the patient receives nearly as much the physician's engagement and responsiveness with the actual patient. Unfortunately, many physicians are not trained to use EHRs and simultaneously maintain a verbal rapport and interpersonal communication with the patient, as they will become focused on one task or the other--but not both. As the Subcommittee considers having all FEHBP participants use electronic medical records, it is critical to consider seriously both the positive and negative implications that can result from such practices, and make decisions about what truly is in the best interest of the patient.

This concludes my statement. I will be happy to answer any questions that the Chairman or other Members of the Subcommittee may have.

Mr. PORTER. Next, we have Archelle Georgiou, Doctor, executive VP, strategic relations, specialized care services, UnitedHealth Group. Thank you for being here.

STATEMENT OF ARCHELLE GEORGIOU, M.D.

Dr. GEORGIOU. Thank you, Chairman Porter and distinguished members of the committee, for the opportunity to testify before you at today's hearing on how the use of health information technology can improve the health of Federal employees and annuitants and their families.

I am Archelle Georgiou, physician and executive vice president of strategic relations with specialized care services, a specialty health and well-being division of the UnitedHealth Group. Headquartered in Minneapolis, MN, UnitedHealth Group offers a broad spectrum of products and services through six operating businesses: UnitedHealth Care, Ovations, AmeriChoice, Uniprise, Specialized Care Services and Ingenix. Through its family of businesses, UnitedHealth Group serves approximately 65 million individuals nationwide.

UnitedHealth Group has extensive experience providing health care services to the Federal Government, State governments and private payers in many types of competitive environments. Currently, we offer health benefits to Federal employees under the Federal Employees Health Benefits Program in 14 States. We have more than 322,000 members enrolled in our various FEHBP plans and have been a carrier in our FEHBP for over 20 years.

As Jeannine Rivet testified before this subcommittee in March, UnitedHealth Group is a strong supporter of using health information technology to advance the quality of care provided to individuals and to improve the efficiency of our health care system. Over the past 5 years, we have invested $2.5 on technology in an effort to bring simplicity and enhanced administrative efficiencies to the U.S. health care system.

In 2000, UnitedHealthcare introduced its consumer service Web site, myuhc.com, to provide members with easy access to health information and services so they can manage their health care effectively. Members logging on to UnitedHealthcare's Web site can find physicians and other providers, find information on hospital quality and order prescription refills online and compare the cost of drug alternatives.

In March 2005, UnitedHealthcare expanded the functionality of our consumer Web site, myuhc.com, by integrating personal health record capability. Easy access offers a secure Web site which protects the privacy and security of members' data with user name and passwords, in keeping with industry authentication and validation standards.

Members can use their personal health records to access a comprehensive record of their medical, surgical, radiology, pharmacy and laboratory health care claim history. This easy-to-read format includes a summary of medical conditions, doctor visits, visit dates, medication history including prescription names, dosages and refill dates, as well as laboratory and radiology tests, including the date and location of these services.

They can enter there and manage self-reporting data, including tracking and charting of wellness indicators. They can also enter and track self-reported data such as glucose levels and blood pressure, as well as information on lifestyle issues such as weight and sleep habits.

Finally, they can print their personal health summary for their personal records and/or use with their practitioner.

While the personal health record is available to all of our members, as of March 2006, 4½ million consumers have accessed their personal health record through our Web portal, myuhc.com.

Of course, the privacy and security of personally identifiable information is of great concern to us all. UnitedHealth Group currently protects members' privacy through the use of standard industry security measures. We are planning to add additional layers of protection to provide our members with even greater assurance that their personal health records are completely secure.

In addition, we automatically suppress data on sensitive health issues to help gain member trust and acceptance of the personal health record feature.

The overall response to our consumer portal and personal health record capabilities has been extremely positive, and we feel it reflects a strong level of comfort on the part of the members regarding the level of privacy and security offered.

Specific to H.R. 4859, we do support your efforts with this bill and look forward to continuing to work with you and your staff as it moves through the legislative process. UnitedHealth Group believes that the use of appropriately designed electronic personal health records will make a significant difference in improving health outcomes for Federal Employees Health Benefits Program participants and will make it easier for them to manage their health care effectively.

Since the FEHBP covers such a large member population, we believe requiring the use of electronic personal health records by program carriers and providers could have a significant impact on driving the entire industry forward on this very important matter. Moreover, the use of electronic personal health records could help reduce disparities in health care.

As Speaker Gingrich stated in previous testimony before this committee, participants for whom English is a second language would be better served by being able to provide their physicians with access to their complete health record, rather than having to try to explain complex medical issues in a second language. They could also provide access to their records to family members with greater proficiency in English to assist in their medical encounters.

In conclusion, our experience in offering consumers a personal health record as well as our research to determine the key needs of consumers as related to a personal health record have enabled us to identify a number of requirements for facilitating widespread adoption. These requirements for success include a strong and consistent information and education campaign that clearly shows the value of using a personal health record to consumers; a tailored consumer experience, organizing data and features in a manner that makes it easier to navigate and access information of choice, with health information displayed and described in ways that are

easy to understand; secure and private infrastructures and processes; accurate and timely information to build trust and credibility; flexibility to address consumer needs, preferences and desires; health records integrated so that individuals have easy access to the PHR from the carrier's consumer portal and easy access back; and interoperability with provider office technology.

Chairman Porter, we appreciate your continued leadership in this matter and commend you and the members of the subcommittee for your appreciation of the benefits and value that health information technology can bring to the quality, efficiency and effectiveness of health care.

Thank you.

Mr. PORTER. Thank you, Doctor. I appreciate your testimony and the fact that you are a Nevadan. We appreciate that.

And I tell you, having talked to some of your participants from across the country, they like the fact that they now know what information you have on them, which they didn't know before; and they are happy to have that access. So thank you very much.

Dr. GEORGIOU. Thank you. And it is helpful because at times we can get misinformation when claims are submitted from physicians, and they can help us correct that information as well.

Mr. PORTER. Thank you.

[The prepared statement of Dr. Georgiou follows:]

Testimony of
Archelle Georgiou, M.D.
Executive Vice President
Specialized Care Services
UnitedHealth Group

For

The U.S. House of Representatives
Committee on Government Reform
Subcommittee on the Federal Workforce and Agency Organization

Hearing on H.R. 4859
"Federal Family Health Information Technology Act of 2006"

June 13, 2006

Introduction

Thank you Chairman Porter, Representative Davis and distinguished members of the Committee for the opportunity to testify before you at today's hearing on how the use of health information technology can improve the health of federal employees and annuitants, and their families. I am Archelle Georgiou, Executive Vice President of Strategic Relations with Specialized Care Services (SCS), a specialty health and well-being division of UnitedHealth Group. UnitedHealth Group (www.unitedhealthgroup.com) is a diversified health and well-being company dedicated to improving the health care system and helping people achieve improved health and well-being through all stages of life. Headquartered in Minneapolis, Minnesota, UnitedHealth Group offers a broad spectrum of products and services through six operating businesses: UnitedHealthcare, Ovations, AmeriChoice, Uniprise, Specialized Care Services and Ingenix. Through its family of businesses, UnitedHealth Group serves approximately 65 million individuals nationwide.

UnitedHealth Group has extensive experience providing health care services to the federal government, state governments and private payers in many types of competitive environments. Currently, we offer health benefits to federal employees and annuitants under the Federal Employees Health Benefits Program in 14 states – Arizona, California, Colorado, Illinois, Iowa, Maryland, Missouri, Nevada, Ohio, Oklahoma, Oregon, Texas, Virginia, Washington – and the District of Columbia. We have more than 322,000 members enrolled in our various FEHB plans. These plans include M.D. IPA in the Mid-Atlantic (DC, MD, VA), PacifiCare in the West (AZ, CA, CO, NV, OK, OR, TX, WA), UnitedHealthcare (CO, MO, OH) and John Deere Health Care (IL, IA). Through our various plans, we have been a carrier in the Federal Employees Health Benefits Program for over 20 years.

As Jeannine Rivet testified before this Subcommittee in March, UnitedHealth Group is a strong supporter of using health information technology to advance the quality of care provided to individuals and to improve the efficiency of our health care system. Over the past five years, we have invested $2.5 billion on technology in an effort to bring simplicity and enhanced administrative efficiencies to the U.S. health care system. Our investment in technology allows us to apply a data-driven approach to provide plan members with information about the cost and effectiveness of different treatment options, as well as to help them find the highest-quality providers. Health care delivery remains complex and fragmented, and if critical information is not available at the point of care, medical errors, duplication and waste can result. Our technology supports automatic, seamless and patient-centered information flow, and it puts control of the information in the hands of the patient. We strongly believe that patient-empowered exchange of health care information will improve quality and affordability of care. Moreover, by preparing and encouraging patients to make informed health care decisions, they will maximize the value they receive for their health care dollar, enjoy better health and more easily manage their health care.

myuhc.com

In 2000, UnitedHealthcare introduced its consumer service website, myuhc.com, to provide members with easy access to health information and services so that they can manage their health care effectively.

Members logging on to UnitedHealthcare's website can:

- Find providers designated under the UnitedHealth Premium[SM] program which identifies providers who meet objective quality and efficiency criteria based on claims-related data that compare physician complication rates and practice patterns with evidence-based medical guidelines
- Find information on hospital quality, including data on patient safety, length of stay, mortality, patient volume and complications for more than 150 procedures
- Order prescription refills online and compare the cost of drug alternatives
- Receive actionable information, based on their claims, related to improving the quality of their care and achieving cost savings. For example, members who have experienced heart attacks but have not filled prescriptions for beta blockers – which have proven efficacy in reducing future heart attacks – receive messages encouraging them to talk with their doctors about the benefits of beta blockers. Members who fill prescriptions for brand-name drugs receive messages indicating how much they could save by switching to equally effective generic alternatives.
- Receive monthly statements online providing explanations of benefits for all services

In March 2005, UnitedHealthcare expanded the functionality of myuhc.com ,the consumer website by integrating personal health record capabilities that give consumers the ability to enter and track self-reported health information. In November 2005, the functionality was further expanded and members' claim based information was automatically pre-populated into their personal health record. Access to this information gives consumers control over their health data in order to inform and empower decision making. Easy access through myuhc.com offers a secure website which protects the privacy and security of members' data with user names and passwords, in keeping with industry authentication and validation standards.

Over the past year, our members have used their personal health records to:

- Enter and manage self-reported data, including tracking and charting of wellness, medical history, contacts with health care practitioners and notes/observations about their own health
- Enter and track self-reported clinical data, such as glucose levels and blood pressure, as well as information and lifestyle issues affecting health, such as weight and sleep habits

- Access a comprehensive record of their medical, surgical, radiology, pharmacy and laboratory health care claim history. This includes a two year summary of medical conditions, doctor visits and visit dates, medication history including all prescription names, dosage, and refill dates, laboratory and radiology tests including the date and location of the service.

- Capture personal and family contact data

- Print their personal health summary for their personal records and/or use with their practitioner

While the personal health record is available to all of our members, as of March 2006, 4.5 million consumers accessed their personal health record through our web portal, myuhc.com.

Personal Health Records Research

In an effort to refine our personal health record and to make it more responsive to consumer and physician needs, in November 2005 we employed an independent research firm to conduct qualitative research on the personal health record concept and to determine the needs and interests of consumers. Through a number of in-depth telephone interviews and focus group sessions with consumers, physicians and employers/payers, the research revealed some interesting findings that have helped us to identify ways to make our personal health record even more useful to consumers and their doctors.

Consumers

We were very encouraged to learn through our research that the majority of consumers are positive toward the personal health record concept and are open to using it. In fact, according to this research, consumers see many advantages to such a service. Some of the specific key findings for this group include:

- Accessibility, portability and convenience are the key benefits of a personal health record to consumers. Having easy access to their medical records is highly valued, and consumers recognize that with a PHR they can take their information wherever they need it. They also think personal health records make managing their health care more convenient.

- Consumers generally believe a personal health record will help patient-physician interactions. They believe it would help their physician be more informed about their history. They see it as especially helpful for elderly patients or people with chronic conditions.

- Internet security and privacy are the primary concerns consumers have with personal health records. This concern is due in large part to the extremely sensitive – and vital – nature of health information that must be safeguarded against any form of abuse. That said, though, many consumers believe these security and privacy concerns can be

overcome through the use of multi-level passwords and the ability to designate who has access to what information.

- Consumers want the right to limit access to the information in their PHR; however, most indicated they would provide full access to their physician.

- Consumers are comfortable with a health plan providing or supporting this service.

Overall, assuming privacy issues are addressed and the service is free, most consumers indicate they would adopt a personal health records. The ability to easily access their records and the convenience it would provide are the primary motivators.

Physicians

We found that awareness of personal health records is mixed among physicians. While several of the physicians in our studies said they have a general understanding of the concept, others were simply unaware of it. Once the concept was explained to them, they had the following reactions:

- Like consumers, physicians responded favorably to the concept. Easy access to patient health records provides two key benefits to physicians: accessibility will allow physicians to provide better care to patients, and easy access to patient records is expected to improve efficiency in physician practices.

- Physicians believe the key benefits of a PHR to consumers are better care, feeling more empowered and portability of their medical records. With doctors having more complete medical information, patients may have fewer problems with drug interactions, fewer tests repeated and a quicker resolution to their problem.

- Physicians' key concerns, like consumers, are privacy of patient data, as well as cost and accuracy of patient-entered data. Several expect it will be expensive to implement personal health records, and the idea of patients entering their own data received mixed reactions from physicians; they worry that patients may edit doctors' notes or enter incorrect data.

- Most physicians are opposed to allowing an "opt out" capability that would allow patients to block some information from being accessed by their health care provider.

- Most physicians we spoke with indicated they would be interested in adopting personal health records. Their main reasons for doing so are to obtain access to patient records and to achieve efficiencies in their practice.

Employers

The research into employers' perceptions of personal health records revealed that there is little awareness of, and experience with, personal health records among employers. Moreover, we

found that employers tend not to see a clear or consistent benefit to them in making personal health records available to their employees, although they clearly see value for their employees and would encourage them to use the records. Other key findings include:

- They believe that having access to their medical records would allow employees to better manage their health care and keep track of doctor's visits, medications, etc.
- Some employers believe that employees may be more likely to use wellness, care management or preventative care services. They think that employees may become more aware of these services if tied to a personal health record and, consequently, may use them more often.
- They believe that confidentiality and security will be a key concern of employees.
- They are comfortable with health plans providing their employees with access to personal health records; they would view that as an added service by the plan.
- Employers desire ease of navigation, integrated reporting and more of an outcomes focus.

So overall, while employers are mixed on their likelihood to offer a personal health record for their employees, they clearly see the value to their employees and are comfortable with their health plans making personal health records available. They see consumer education on the ease of use, benefits, security and confidentiality as key to getting their employees to use personal health records.

Refinements to UnitedHealth Group's Personal Health Record

In June 2006, members will have the option of giving selected physicians and family members access to their personal health records. Such access gives doctors a more comprehensive view of patients' health information than they would have from their own records so that they can provide care best suited to patients' needs, preferences and prior use of services. Members can grant their physicians access to their Personal Health Summary, a printable health summary detailing the most recent medical, surgical, radiology, pharmacy and laboratory health care claim history viewable online or through swipe card technology.

In addition, we plan to add more features such as allowing members to restrict access to certain portions of their records. We also will conduct member satisfaction surveys to identify how to continue to enhance the capabilities of the personal health record as well as to evaluate the extent to which personal health records are leading members to enroll in disease management and wellness programs, access UnitedHealthcare's 24-hour nurse advice line, use the nurse chat room function and undertake other activities that promote health and well-being.

Privacy and Security

The privacy and security of personally identifiable information is of great concern to us all. If that information involves our specific medical needs and treatments, its sensitivity is even greater.

UnitedHealth Group currently protects members' privacy through the use of standard industry security measures such as user names and passwords. We are planning to add additional layers of protection to provide our members' with even greater assurance that their personal health records are completely secure.

In addition, we automatically suppress data on sensitive health issues such as sexually transmitted diseases, mental health, substance abuse, and reproductive health. We took this step of automatically suppressing this data to further protect privacy and to help gain member trust and acceptance of the personal health record feature.

The overall response to our consumer portal and personal health record capabilities has been extremely positive and, we feel, reflects a strong level of comfort on the part of members to the level of privacy and security offered.

Comments on H.R. 4859

Specific to HR 4859, we do support your efforts with this bill and look forward to continuing to work with you and your staff as it moves through the legislative process. UnitedHealth Group believes that the use of appropriately-designed electronic personal health records will make a significant difference in improving health outcomes for Federal Employees Health Benefits Program (FEHBP) participants and will make it easier for them to manage their health care effectively.

We think personal health records can be particularly helpful for the many annuitants who participate in FEHBP. In the aggregate, this group tends to have more chronic conditions, which may mean multiple physicians and multiple prescription medications. Having access to a personal health record that provides easy access to their collective information will make it simpler for them, their care-givers and providers, to track and manage their conditions and health care needs. Since the FEHBP covers such a large member population, we believe requiring the use of electronic personal health records by program carriers and providers could have a significant impact on driving the entire industry forward on this important matter.

Moreover, the use of electronic personal health records could help reduce disparities in health care. As Speaker Gingrich stated in previous testimony before this Committee, participants for whom English is a second language would be better served by being able to provide their physician with access to their complete health care record, rather than having to try to explain complex medical issues in a second language. They also could provide access to their records to family members with greater proficiency in English to assist in their medical encounters.

If we may offer one cautionary comment as you move forward. There are a number of models of personal health records being offered to consumers. Since they are still an evolving feature of our health care system, no one knows for sure yet what approach will truly get consumers what they need and will use. However, our efforts and research have shown us that the most effective approach is a simplified approach. Therefore, as you move forward with your efforts to advance this critically important health care service, we would ask that you continue to provide flexibility for the market to determine what consumers want and what will get them fully engaged so that we can design and refine personal health records to best meet their needs.

Conclusion

In conclusion, our experience in offering consumers a personal health record, as well as our research to determine the key needs of consumers as related to a personal health record, have enabled us to identify a number of requirements for facilitating widespread adoption. These requirements for success include:

- A strong and consistent information and education campaign that clearly shows the value of using a personal health record to the consumer
- A tailored consumer experience, organizing data and features in a manner that makes it easy to navigate and access information of choice, with health information displayed and described in ways that are easy to understand
- Secure and private infrastructures and processes
- Accurate and timely information to build trust and credibility
- Flexibility to address consumer needs, preferences and desires
- Health records fully integrated so that individuals have easy access to their PHR from the carrier's consumer portal and easy access back to the consumer portal from the PHR
- Interoperability with provider office technology

Chairman Porter, we appreciate your continued leadership in this matter and commend you and the Members of this subcommittee for your appreciation of the benefits and value that health information technology can bring to the quality, efficiency and effectiveness of health care.

We are confident that the use of appropriately-designed personal and electronic health records will make a significant difference in improving health outcomes for individuals and will make it easier for them to manage their health care effectively. Again, we appreciate your leadership on this very important matter and thank you for the opportunity to share our experiences in offering a carrier-based personal health records. I would be happy to answer any questions you might have for me.

Mr. PORTER. Next, we have Stephen Gammarino, senior vice president, national programs, Blue Cross and Blue Shield Association. Welcome.

STATEMENT OF STEPHEN W. GAMMARINO

Mr. GAMMARINO. Thank you, Chairman Porter and members of the subcommittee, for giving the Blue Cross and Blue Shield Association an opportunity to present our views on H.R. 4859.

I will cover three main areas in my testimony today: First, a strong support of Blue Cross Blue Shield plans in advancing health information technology; second, an overview of OPM's market-oriented approach to health information technology; and, third, our concerns and recommendations related to this important issue.

First, we commend, Mr. Chairman, you and the subcommittee for your support for health information technology.

Now, for my first point, Blue Cross Blue Shield plans and the Association are committed to advancing health information technology. We are committed to a health care system that delivers safe, efficient and high-quality care. We recognize that the goal requires nationwide standards for interoperability, and we have a record of support and commitment. For example, we serve on Secretary Leavitt's American Health Information Community. We are collaborating with America's health insurance plans to develop industry standards related to health information records, and we supported legislation that would require and spur development of industrywide interoperability.

My written statement provides several examples of plan leaderships and lessons learned. For example, we have learned that nonproprietary interoperability standards are critical to facilitate data exchanges; second, we know that providers must see value in records and they must be integrated into the providers' workflow; and, three, perhaps most important, we learned that members must see value in using the personal health records.

The second point is an overview of the OPM's market-oriented approach.

As most of us know, the FEHBP has a long history of being cited as a model for employer-sponsored health benefit programs. A lot of that strength is reliance on market forces of competition and consumer choice.

Historically, Congress has exercised a light touch in imposing statutory mandates, and we believe this market-oriented approach has resulted in innovation in the program over the last 40 years.

As you know, most recently, OPM, in their 2007 call letter, provided for short-term information technology objectives which focus on enhanced member education, payer-based personal health records, incentives for e-prescribing, linking disease management programs to health information technology, having requirements to protect individual health information, and providing financial incentives for carriers.

The market-oriented approach has already led to health information advances in the Blue Cross Blue Shield Service Benefit Plan.

Over the last couple of years, we worked with the agency in a program called Care Coordination.

We are currently applying health information technology to an integrated data base to ensure that, among our sickest members, that they receive the right treatment at the right time.

We think a market approach is superior to any legislative mandate. It relies on marketing incentives, rather than one-size-fits-all. Carriers that are slow to offer personal health records, for example, risk punishment in the marketplace as consumers who value them gravitate to other carriers. It also allows each carrier to meet a member's needs.

In responding to one of the questions that Congressman Davis has put before the panel earlier today, we think pilot projects are critical. Without members use and provider acceptance, the health records will not have the impact we all hoped for.

My third point focuses on our concerns about this bill and our recommendations for establishing health records in this program.

First concern, we think the bill is premature until the necessary standards have been developed and fully tested; second, OPM's current market-based approach, as exhibited in a recent call letter, makes this legislation we think unnecessary at this time; third, the bill does not recognize cost being allowed to be charged to the program and being reflected in a carrier's premiums; and, fourth, the bill imposes unprecedented mandates on a carrier's resource and therefore we think sets a bad precedent.

In closing, Blue Cross Blue Shield has two recommendations: first, that OPM and carriers follow a market-based approach on health implementation technology as outlined in OPM's most recent call letter; and, second, strong congressional oversight to hold both the agency and the carrier accountable for introducing the introduction of appropriate health records. We are confident you will find Blue Cross Blue Shield a leader in effective introduction of those health records.

Mr. Chairman, that concludes my oral statement. I will be happy to address any questions you may have.

Mr. PORTER. Thank you very much.

I know I mentioned earlier but I would like to reiterate it again, I applaud Blue Cross Blue Shield because literally in 78 hours or 42 hours or 20 hours—I can't remember what it was—you transferred your participants after Katrina in preparation for Rita so they wouldn't lose their files.

Mr. GAMMARINO. It was probably within 700,000 and 800,000.

Mr. PORTER. How many days?

Mr. GAMMARINO. It was a matter of days.

Mr. PORTER. Well, I applaud you for those efforts. So thank you very much for taking care of those folks.

[The prepared statement of Mr. Gammarino follows:]

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TESTIMONY OF

Blue Cross & Blue Shield Association
An Association of Independent
Blue Cross & Blue Shield Plans

Before the

Subcommittee on Civil Service and Agency Organization
Committee on Government Reform
United States House of Representatives

On

"Healthier Feds and Families: Introducing Information Technology into the Federal Employees Health Benefits Program, a Legislative Hearing on H.R. 4859, Part II"

Presented by:

Stephen W. Gammarino
Senior Vice President
National Programs

Tuesday, June 13, 2006

Good morning. Chairman Porter, Ranking Member Davis, and Members of the Subcommittee, I am Stephen Gammarino, Senior Vice President, National Programs, of the Blue Cross and Blue Shield Association. Thank you for this opportunity to present the views of the Blue Cross and Blue Shield Association Federal Employees Program on the Federal Family Health Information Technology Act of 2006, H.R. 4859.

The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans jointly administer the Government-wide Service Benefit Plan in the FEHBP. We are proud to have offered the Service Benefit Plan from the very beginning of the FEHBP in 1960. Today, the Service Benefit Plan provides high-quality, affordable health insurance to more than 4.6 million active and retired federal employees and their families. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

My testimony today will focus on three areas:

I. The Association and Blue Cross and Blue Shield Plans' strong support and commitment to advancing health information technology, including examples of what we are currently doing;

II. An overview of OPM's market-oriented approach, which has contributed to the success of the FEHBP program by relying on strong competitive forces rather than regulation; and

III. Our concerns with the bill and our recommendation to advance Personal Health Records (PHRs) in the FEHBP through a market-oriented process with active congressional oversight.

THE ASSOCIATION AND BLUE CROSS AND BLUE SHIELD PLANS ARE COMMITTED TO ADVANCING HIT.

The Association commends you, Mr. Chairman, and the members of the subcommittee for your interest in Health Information Technology. The Association is very supportive of advancing health IT in general and of offering PHRs in the FEHBP in particular. (We use "PHR" to encompass both the carrier-based electronic health record and the personal electronic health record established by the bill.)

Blue Cross and Blue Shield Plans are committed to a health care system that delivers safe, efficient, and high-quality care for consumers – giving consumers greater value for their health care dollars – as well as increased administrative efficiency for providers, payers, government, and consumers. Achieving this goal requires nationwide adoption of health information technology (IT) that is based on interoperability standards that support the exchange of clinical and administrative information among providers, payers, government, and consumers, and that includes the tools providers need to deliver high-quality, evidence-based health care.

We especially applaud your decision, Mr. Chairman, to embrace payer-based electronic health records. Payer-based records are a natural extension of what insurers do because they are compiled from claims data submitted by providers to health plans: diagnoses, procedures, medication history, immunizations, recent health encounters, etc. More important, payer-based EHRs are particularly exciting because health plans are generally the only stakeholder in the health care system that collects information from almost all providers that their members visit and, therefore, the only stakeholder at this time that can give a physician a cross-provider view of a patient's history. Carriers are also uniquely positioned to integrate electronic health records

with disease and care management programs that benefit those with the most challenging health problems. Payer-based PHRs will also facilitate the use of clinical tools and evidence-based medicine at the point of care.

Association Leadership on HIT

The Association's commitment to advancing health IT has been demonstrated by our actions. Scott Serota, the Association's CEO, serves, along with OPM Director Springer and others, on the American Health Information Community ("the Community"). As you know, HHS Secretary Leavitt appointed the Community, which comprises representatives of all of the key stakeholders - both public and private - in the healthcare industry, to advise him on how best to advance health information technology. Under the Secretary's leadership, the Community provides a forum in which a broad range of stakeholders provide input on achieving interoperability of health IT, and it will recommend specific actions to achieve a common interoperability framework for health IT.

When he accepted this appointment, Mr. Serota emphasized that "Blue Plans are leaders in advancing health IT, including interoperable systems, personal health records, e-prescribing, and information sharing to improve care, as well as other projects," and that "We look forward to working with other key stakeholders to advance the nationwide adoption of health information technology. This will enable safer, more efficient and higher quality care for all."

We have also joined forces with America's Health Insurance Plans (AHIP) –and are coordinating with the Health Information Technology Standards Panel – in a collaborative effort to define the minimum data elements of personal health records (PHRs) and develop standards to facilitate their interoperability and portability. The FEP is participating in this critically important project.

The Association has also supported legislation that would spur the development of industry-wide interoperability standards. For example, the Association has endorsed those provisions of H.R. 4157 that would establish such standards through public-private collaboration and harmonize state and federal privacy and health IT laws.

Plan Leadership on HIT & Lessons Learned

Many of our Plans are in the forefront of implementing PHRs and other innovative advances in health IT. Let me just briefly highlight a few examples, some of which are already known to the subcommittee:

- BCBS of Delaware and the Christiana Care Health System have developed a system for providing Christiana's emergency room doctors with real-time health records on the Plans' members.
- BCBS of Texas, aware of the debilitating effects Hurricane Katrina had on the delivery of health care to many affected by the hurricane, undertook the Herculean task of creating 830,000 PHRs for its members who were threatened by Hurricane Rita. (I am pleased to reassure members of the subcommittee that the Service Benefit Plan is already well equipped to provide our members access to their health information, including prescription drug information, in the event they are affected by a disaster.)
- HCSC, of which the Texas Plan is a division, is implementing PHRs for its members.

- Arkansas BCBS, two of Arkansas's major providers, and IBM established the Arkansas Health Information Network in 1995, one of the first interoperable networks for exchanging health information between payers and providers, including since 1996 electronic health records.

The experiences of these Plans and others have yielded valuable lessons. Let me mention a few:

- Non-proprietary interoperability standards are critical to facilitate the exchange of data.
- Providers must see value in such records and they must be integrated into the providers' workflow in order to spur adoption.
- Members must see value in using their PHRs.

OVERVIEW OF OPM'S FLEXIBLE, MARKET-ORIENTED APPROACH

Historically, the strength of the FEHBP – which has made it a model employer-sponsored health benefits program – has been its reliance on the market forces of competition and consumer-choice, which has provided OPM and carriers the flexibility necessary to adapt to changing conditions and emerging trends. Unlike Medicare, another government health program, Congress has exercised a "light touch" and restraint in imposing statutory specifications. We believe that reliance on the marketplace and the freedom to innovate afforded to carriers are features that have made the FEHBP successful for more than forty years.

OPM'S Call Letter for 2007

OPM's call letter for 2007 prescribes a market-oriented path that harnesses both financial incentives and consumer empowerment to advance health IT in the FEHBP. Under that call letter, FEHBP carriers are expected to meet five short-term objectives:

1. Enhance member education on how health information technology can help improve health care quality and control costs in the long run;

2. Offer payer-based PHRs to enrollees based on information currently available in their systems;

3. Encourage pharmacy benefit managers to provide incentives for ePrescribing; and

4. Link disease management programs to health information technology;

5. Comply with federal requirements to protect members' individually identifiable health information.

Within the next two to four years HIT adoption will become an element in each carrier's performance review, which determines the amount of each carrier's service charge. In the upcoming open season, prospective employees will be able to review information on carriers' HIT capabilities on OPM's website as they decide which health care plan to choose for 2007. The agency will also highlight plans with "state-of-the art HIT capabilities."

The Market-Oriented Approach Has Already Led To HIT Advancements in the Service Benefit Plan.

The market-based model reflected in the call letter and the Association's commitment to health IT have already led to advances in the Service Benefit Plan and we believe it will serve the introduction of PHRs equally well. I would like to review some of those advances for the benefit of the subcommittee.

We have worked closely with OPM for several years on an important, member-centric program, called Care Coordination. Care Coordination applies health information technology to an integrated database in order to improve our members' health care.

Care Coordination focuses on those with chronic conditions, diabetics for example. Under it, we will use claims data, including prescription drug information, and information from enrollment forms to identify those members who would benefit from our Plans' disease or case management programs, to work with our local Plans to educate those members about the benefits of such programs, and, we hope, to persuade members to take advantage of those programs. Initially, Care Coordination will provide a single point of entry to a seamless health care system for Plan disease and care management directors. But our goal is to extend access to this data to providers and then, in the next stage, to develop a mechanism to allow individual members to access their own data.

Currently, eleven Plans are participating in this program. We anticipate that all Plans will be part of the program by 2008. We believe the implementation of this program will substantially improve the health care received by those who need it most and strengthen their ability to manage their medical conditions.

Many believe, as Dr. Paul Handel, the Vice President and Chief Medical Officer of Blue Cross Blue Shield of Texas, testified before this subcommittee in March, that PHRs will have the greatest values for our sickest members, those who need care or disease management programs. Accordingly, among several other options, we are examining whether it would be appropriate to pilot PHRs in our Care Coordination program.

We have also strongly supported another HIT initiative, e-prescribing to improve patient safety and reduce drug costs by delivering patient-specific drug benefit and medication history to physicians at the point of care. Working with our PBM (Caremark) and two Plans (Horizon Blue Cross and Blue Shield in New Jersey and Blue Cross Blue Shield of Tenessee), we are conducting a pilot program to encourage high prescribers to adopt this technology by providing incentives, including the purchase of software and funding other start-up costs. Thirty-four physicians in Tennessee and ninety-seven in New Jersey have enrolled in the program.

I would also note that Blue Cross and Blue Shield Service Benefit Plan members may already use the Health Tracker feature of the web-based Blue Health Connection (the Service Benefit Plan's health information site) to store health information on themselves and their families on a confidential basis.

Market Approach is Superior to Legislated Mandates

In our view, the call letter's flexible, market-oriented approach in which carriers work closely with OPM to develop electronic health records that truly reflect their members' values and keep pace with developments in the health care industry as a whole is the best approach for developing PHRs in the FEHBP. Let me explain why. It:

- **Relies on Market Incentives Rather than One-Size Fits All Mandates.**

OPM's market-driven approach harnesses both financial incentives and consumer empowerment to direct the development of HIT. Carriers that are slow to offer PHRs, for example, risk punishment in the marketplace as consumers who value them gravitate to other carriers.

- **Recognizes that Each Carrier Is the Best Judge of Its Members' Needs**

Each carrier will know best how to meet the needs of their own members. Some may put the highest priority on developing PHRs, while others might persuade OPM that their scarce IT resources should be allocated first to other HIT initiatives, such as e-prescribing or care management. The call letter does not impose a "one-size-fits-all" mandate.

- **Facilitates Pilot Projects That are Critical to Success.**

Pilot projects are critical in our view to the effective development of PHRs. Unless our members actually make use of their PHRs and there is widespread acceptance among providers, the electronic health records called for in the bill simply will not have the impact we all hope for. These are key non-technological challenges and pilot tests will likely be critical to developing and refining PHRs that members will perceive as an attractive tool they want to use and that providers will accept. Moreover, since we are just now beginning to learn what information is useful and how to educate consumers and providers of the value PHRs can provide, the flexibility to continue to innovate is essential.

The call letter allows us to work with the agency in conducting the necessary experiments and to refine our PHR and our educational efforts in line with our experience to most effectively meet our members' values without the constraints imposed by arbitrary deadlines. In contrast, there is no explicit provision in the bill for pilot programs, and the bill's firm deadlines are likely to preclude them.

- **Focuses on PHRs as Means Not Ends**

The ultimate goal of PHRs is to improve the quality, safety, and efficiency of health care for those who participate in the FEHBP. In contrast, requiring carriers to establish PHRs in accordance with tight and inflexible deadlines tends to focus on PHRs as ends rather than means and is more likely to benefit vendors who market proprietary PHRs than the active and retired federal employees and dependents who rely on the FEHBP for their health care coverage. Carriers will be pressured to

offer a product by a date certain rather than take the time necessary to develop one that best reflects their members' values.

CONCERNS AND RECOMMENDATIONS

I would like to discuss some of our major concerns with this legislation, explain why we believe no legislation is necessary to advance PHRs, and recommend the market-oriented path described in OPM's call letter as a superior route for introducing PHRs into the FEHBP.

Concerns

At the very least, we believe this legislation (or any other mandatory legislation) is premature. The standards needed to support PHR functions, interoperability, and portability required by the bill simply do not exist today. Many organizations, including BCBSA and other private and public bodies, are working hard to develop such standards. But there can be no assurance they would be thoroughly tested and in place when the bill's various deadlines fall.

Because we firmly believe that the FEHBP's reliance on market competition and consumer choice have been its strengths, the Association has historically objected to statutory mandates on the program – and, indeed, even to overly prescriptive call letters. This bill would establish an unprecedented mandate on how FEHBP carriers deploy their information technology resources and other internal infrastructure. Carriers would not have the flexibility they need to direct their resources in the manner that would most effectively meet their members' needs. Thus, we are very concerned that the bill would establish a dangerous precedent for other legislation that would dictate the internal business processes of FEHBP carriers. The Service Benefit Plan is fully integrated with Local Blue Cross and Blue Shield Plans' commercial business. Accordingly, this mandate is particularly problematic for us since it could affect our Local Plans' commercial business operations.

Section 3 of the bill is particularly problematic and not workable.

First, it would change current law to deny the inclusion of valid costs associated with the development of PHRs in the setting of a plan's premiums. This would be an uncompensated burden on carriers. Section 3 mistakenly attempts to offset these costs by providing that neither monetary savings nor returns on investment resulting from PHRs will be taken into account in rate setting. Again, section 3's premise is false in that experience-rated carriers, such as the Service Benefit Plan, have no way of taking into account "savings" on benefits costs; only the actual costs incurred are used in setting rates. While reducing benefit costs is always a goal, it would be impossible to attribute specific reductions in benefit costs to the introduction of PHRs as opposed to other system changes and administrative actions.

Second, and equally adverse, section 3 would also change the longstanding statutory provision whereby the unused portion of OPM's administrative reserve is rolled into carrier's contingency reserves for the payment of claims and rate stabilization. This would not only establish a dangerous precedent of using the contingency reserves for other than the statutorily-intended purposes, but would cause an upward pressure on a plan's premiums by the amount of the foregone reserves.

In short, section 3 not only is unworkable, but it does not accomplish either of its stated purposes.

Legislation is Unnecessary to Bring PHRs Into the FEHBP

There is already a high level of activity that will facilitate the introduction PHRs. An HHS contractor will recommend PHR standards to the Community by September 30, 2006, and Secretary Leavitt has said that he expects federal agencies to incorporate them in their health care contracts. The BCBSA/AHIP joint venture is also following an aggressive schedule that calls for the development of standards in August. Just as legislation was not required to introduce Care Coordination or our e-prescribing incentives, we do not believe it is necessary to bring PHRs to the FEHBP. To put it simply, OPM's call letter guarantees that interoperable PHRs are coming to the FEHBP in timely fashion.

In keeping with our long tradition of providing first-rate health care coverage to federal employees and retirees, the Association is committed to being a leader in the *effective* use of health IT in the FEHBP and has begun market research on PHRs. We recognize that unless enough of our members actually use their health records, the promise of PHRs will remain unfulfilled. Therefore, one of the key challenges we face is to develop a PHR that our members will perceive as a value and want to use. For those reasons, we are conducting market research to better understand what consumers know about PHRs, what their concerns are, what would be valuable to them, and what barriers might prevent our members from making effective use of a PHR. We will use what we learn about our members' values, as well as lessons we learn from the experiences of the many Blue Plans that offer PHRs, to develop a PHR and pilot test it in the FEHBP as appropriate.

Recommendation

We strongly recommend that OPM and carriers be permitted to follow the market-based path set forth in OPM's call letter with active congressional oversight to hold the agency and carriers accountable for achieving the bill's objectives with strong congressional oversight. This approach will provide OPM and carriers the flexibility they need to ensure that the PHRs offered to our members truly reflect their values and maximize the prospect that they will be used. But it will also afford congress ample opportunity to hold the agency and carriers for meeting the objectives of the bill.

Congress obviously has a legitimate interest in ensuring that the FEHBP offers federal employees and retirees the benefits that technology can offer when effectively deployed. We believe, however, that congressional oversight would make a far more constructive contribution than legislated mandates. Congress has many oversight tools available, including conducting hearings and requiring periodic reports from OPM on the progress in advancing PHRs and other health IT components in the FEHBP. We would welcome and strongly encourage congressional oversight to hold both the agency and FEHBP carriers accountable for achieving the objectives of H.R. 4859 in a timely fashion. We are confident that you will find the Blue Cross and Blue Shield Service Benefit Plan a leader in bringing health PHRs to our members in an effective manner.

CONCLUSION

The Blue Cross and Blue Shield Service Benefit Plan shares your commitment, Mr. Chairman, and that of the Subcommittee, to bring PHRs to the FEHBP. We believe that if properly deployed and used PHRs and health IT in general hold much promise for improving the quality and safety of healthcare, as well as helping to control costs.

However, we do not believe H.R. 4859 is either necessary or the best way to achieve the goal of bringing the benefits of health information technology to the FEHBP. It is not necessary because OPM has already indicated that it expects Plans to focus on offering PHRs and has prescribed a flexible, market-oriented path for achieving that goal. We believe that approach is best calculated to allow us to work with OPM to develop a product that best serves our members' interests and encourage active congressional oversight to hold the agency and carriers accountable. Until industry-wide standards for portability and interoperability and to define core elements of PHRs are developed, thoroughly tested, and in place, we believe legislation is, at best, premature.

Mr. PORTER. Next, we have Joe Witkowski, vice president, Government Employees Hospital Association. Welcome.

STATEMENT OF JOE WITKOWSKI

Mr. WITKOWSKI. Thank you, Mr. Chairman.

My name is Joe Witkowski, and I am vice president of Government Employees Hospital Association.

GEHA is a not-for-profit association of Federal employees, headquartered in Lee's Summit, MO. We are the third largest national health plan within FEHBP and have participated in the program since its inception in 1960. We serve more than 425,000 Federal employees, retirees and their dependents nationwide.

We at GEHA agree with the conclusion that H.R. 4859 has the potential to improve health care quality and reduce medical errors. We also believe it can be used to increase the efficiency of the delivery of medical care, which will result in decreased health care costs.

Easy access to health records is an important goal. Today, I can be in any city in the country; and should my car completely break down I can purchase a new automobile that same day. This can happen because the dealership can electronically access my personal financial health history in a matter of minutes.

We believe that individuals and health care providers should also have that same ease of access to a health record. In fact, we have implemented several initiatives, with significant investment in time and technology, to meet those very goals. We are participating in several pilot projects and have begun implementation of other relevant initiatives. Please allow me to highlight some of our efforts.

GEHA's participating in an employer-based initiative to create a community health record. The organization is called HealthE MidAmerica and is a joint effort between major employers in the Kansas City metropolitan area and Cerner Corp. Cerner is a world leader in developing software for hospitals and physician practices. The goal is to build a patient health record that includes claims data, prescription medication information and clinical data such as diagnosis, procedures and lab results. The patient's health record will also include detail provided and maintained by patients, including information on allergies and any other personal medical history. We believe that our participation in this joint venture will help us develop and grow our health information technology capabilities.

That organization met this morning and formed their board of directors and is starting to move forward in this venture.

We are also participating in a number of HIT initiatives in conjunction with our pharmacy benefit manager [PBM]. Those programs have a special impact on senior citizens. While only comprising 13 percent of the U.S. population, older Americans use 35 percent of all medications dispensed. Twenty-five percent of these seniors fill prescriptions for at least 10 different medications annually. Often, these multiple therapies are prescribed by multiple physicians. Adverse drug events can result from this high medication utilization. Studies show that nearly one in five hospitalizations of older adults each year is due to problems with dosage or inter-

action with prescription drugs. The estimated economic impact of these preventable hospital stays is $177 billion annually.

Our programs are working to counteract this problem. We at GEHA send medical claim data to our PBM on a bi-weekly basis. Our claims data is integrated into the PBM's proprietary software and data base engine which then analyzes patient medical and pharmacy and lab data. Comprised of thousands of clinical rules, the engine uses a predictive model to identify members with an increased near-term risk for hospitalization. We then send alerts to physicians to inform them of our findings.

Using the same integrated data from pharmacy, medical and laboratory sources, our PBM stratifies GEHA members into four patient populations: well, acute, chronic and complex. The pharmacists use this real-time integrated data to effectively manage, prioritize and optimize specific drug therapies on an ongoing basis. This technology links patients to pharmacists and customer service representatives who act as patient advocates.

In addition, we are participating in a pilot program with our PBM to accelerate the development and adoption of real-time and electronic prescription writing tools for physicians. The goal is to develop a secure, HIPPA-compliant tool that allows patient prescription and medical data to be checked for potential errors as a medication is prescribed.

A new project in development is prescription drug pricing transparency, which we expect to have in place by the end of the year. Members will be able to review and analyze the drug utilization and spend for themselves and their family through the GEHA mail order pharmacy. Using an online tool, members can review their annual drugs and see what generic and brand alternatives are available. The members annual savings for the new therapy will also be shown. If a member opts for a less expensive drug therapy, they can use the same tool to initiate that change online.

Mr. Chairman, I hope that I have made it clear that GEHA embraces information technology as a tool that will help us improve health care quality and reduce medical errors. GEHA has taken several steps toward meeting the spirit of this legislation and will continue to do so.

We respectfully would like to provide some commentary, and first is the issue of liability protection. Providers may be making treatment decisions based on information which is contained within the health record. Data within the record may be incomplete or incorrect. We are concerned we would be included in litigation where medical errors may be made because of the incomplete or incorrect patient health data and need protection from this real possibility.

Chairman Porter, you have publicly stated that you do not want to get ahead of the standards; and your legislation reflects that desire. However, there is a possibility that standards may not be developed in 4 years; and we would be required to move forward during that time. That would cause GEHA and other carriers within the FEHBP program several problems.

GEHA has committed time, money and human capital toward meeting several of the goals contained within the legislation. We are prepared to move forward with plans to offer our Federal members greater information about their claim history and provide

them with tools to build personal health records. We eagerly await the creation and implementation of standards that will move us in this direction. With these in place and further direction from OPM, we will continue to work toward improving the quality of care our members receive and make delivery of health care more efficient.

Mr. Chairman, we look forward to providing additional commentary on this legislation as it moves forward. Thank you for bringing this important discussion to the table and for allowing the GEHA to offer our comments.

Mr. PORTER. Thank you very much for your testimony.

[The prepared statement of Mr. Witkowski follows:]

TESTIMONY OF JOSEPH WITKOWSKI

VICE PRESIDENT

GOVERNMENT EMPOYEES HOSPITAL ASSOCIATION, INC.

FOR THE JUNE 13, 2006 HEARING on H. R. 4859

Mr. Chairman, and members of the Committee, I am Joe Witkowski, Vice President of Government Employees Hospital Association.

GEHA is a non-profit association of federal employees, headquartered in Lee's Summit, Missouri. We are the third largest national health plan within FEHB and have participated in the program since its inception in 1960. We serve more than 425,000 federal employees, retirees and their dependents nationwide.

I have been employed by GEHA for 9 years and worked in the insurance and benefits industry for 32 years. I have earned the designations of Fellow, Life Management Institute (FLMI) and Chartered Life Underwriter (CLU).
Thank you for allowing me to present GEHA's position on health information technology and electronic health records.

We at GEHA agree with the conclusion that H. R. 4859 has the potential to improve health care quality and reduce medical errors. We also believe that it can be used to increase the efficiency of the delivery of medical care, which will result in decreased health care costs.

Easy access to health records is an important goal. Today, I can be in any city in the country, and should my car completely breakdown, I can purchase a new automobile that same day. This can happen because the dealership can electronically access my personal financial health history in a matter of minutes. We believe that individuals and health care providers should also have the same ease of access to a health record. In fact, we have implemented several initiatives, with significant investment in time and technology, to meet those very goals. We are participating in several pilot projects and have begun implementation of other relevant initiatives. Please allow me to highlight some of our efforts.

GEHA is participating in an employer-based initiative to create a Community Health Record. This organization is called HealthE Mid-America and is a joint effort between major employers in the Kansas City metropolitan area and Cerner Corporation. Cerner is a world leader in

developing software for hospitals and physician practices. The goal is to build a patient health record that includes claims data, prescription medication information and clinical data such as diagnosis, procedures, and lab results. The patient health record will also include detail provided by and maintained by patients, including information on allergies and any other personal medical history. We believe that our participation in this joint venture will help us develop and grow our health information technology capabilities.

GEHA is also participating in a number of HIT initiatives in conjunction with our pharmacy benefit manager or PBM. These programs have a special impact on senior citizens. While only compromising 13% of the U S population, older Americans use 35% of all medications dispensed. 25% of these seniors fill prescriptions for at least 10 different medications annually. Often, these multiple therapies are prescribed by multiple physicians. Adverse drug events can result from of this high medication utilization. Studies show that nearly one in five hospitalizations of older adults each year is due to problems with dosages or interactions of prescription drugs. The estimated economic impact of these preventable hospital stays is $177 billion annually.

Our programs are working to counteract this problem. We at GEHA send medical claim data to our PBM on a bi-weekly basis. Our claims data is integrated into the PBM's proprietary software and data base engine which then analyzes patient medical, pharmacy and lab data. Comprised of thousands of clinical rules, the engine uses a predictive model to identify members with an increased near term risk for hospitalization. We then send alerts to physicians to inform them of our findings.

Using this same integrated data from pharmacy, medical and laboratory sources our PBM stratifies GEHA members into four patient populations – well, acute, chronic and complex. GEHA patients will then be assigned to a Therapeutic Resource Center. Therapeutic Resource Centers are a patient-centric model focused on managing patients with chronic and complex conditions who generate the majority of plan costs. At the foundation of this program are trained and accredited pharmacists who specialize in treating only patients with a specific disease conditions. The pharmacists use real-time integrated data to effectively manage, prioritize and optimize specific drug therapies on an ongoing basis. This technology links patients to

pharmacists and Customer Service Representatives who act as patient advocates.

In addition, GEHA is participating in a pilot program with our PBM to accelerate the development and adoption of real time electronic prescription writing tools for physicians. The goal is to develop a secure, HIPAA compliant tool that allows patient prescription and medical data to be checked for potential errors as a medication is being prescribed.

Other GEHA HIT initiatives are linked to our health plan website for GEHA members. In 2001, we developed online WEB accounts for members and providers. These web accounts provide online password protected lookup of GEHA medical and dental claims and eligibility. We are currently exploring the development of provider online submission of claims.

We are continuing to develop tools for member education. In 2002 GEHA launched ***Health e-Report***® an online email newsletter for federal employees and retirees. In each issue are news, updates and expert advice on health and wellness-related topics. Subscribers receive a monthly issue by

email. We have also added website content on preventive care, including recommendations for immunizations and screenings.

A new project in development is drug pricing transparency, which we expect to have in place by the end of the year. Members will be able to review and analyze the drug utilization and spend for themselves and their family through the GEHA mail order pharmacy. Using an online tool, members can review their annual drug spend and see what generic and brand alternatives are available. The members annual savings for the new therapy will also be shown. If members opt for a less expensive drug therapy, they can use the same tool to initiate that change online.

Mr. Chairman, I hope that I have made it clear that GEHA embraces health information technology as a tool that will help us to improve health care quality and reduce medical errors. GEHA has taken several steps towards meeting the spirit of this legislation and will continues to do so.

We respectfully would like to provide some commentary. First is the issue of liability protection. Providers may be making treatment decisions based on information which is contained within the health record. Data within the

record may be incomplete or incorrect. We are concerned with being included in litigation where medical errors are made because of the incomplete or incorrect patient health data and need protection from this real possibility.

Chairman Porter, you have publicly stated that you do not want to get ahead of the standards and your legislation reflects that desire. However, there is a possibility that standards may not be developed in four years and we would be required to move forward during that time. That would cause GEHA and the other carriers within the FEHB program many problems.

GEHA has committed time, money and human capital towards meeting several of the goals contained within the legislation. We are prepared to move forward with plans to offer our federal members greater information about their claims history and provide them with tools to build personal health records. We eagerly await the creation and implementation of standards that will move us in that direction. With these in place and further direction from OPM we will continue to work towards improving the quality of care our members receive and make delivery of healthcare more efficient.

Mr. Chairman, we look forward to providing additional commentary on this legislation as it moves forward. Thank you for bringing this important discussion to the table and for allowing GEHA to offer our comments.

Mr. PORTER. I would like to begin. I guess—one comment. Being from the insurance industry, I don't have a lot of sympathy for some of the insurance industry's comments regarding cost and passing them on to participants, especially the insurance companies that are doing business with a group the size of 9 million people; and I know that has come up a couple of times.

The impact on the bottom lines of some of our carriers, I don't think that is a problem for any of our carriers. I would like to let that be known for our employee base that the last sympathy I have is for the bottom line of some of our carriers, seeing that they are all very substantial and very solvent.

Regarding comments on unprecedented mandates, and I guess this is for Blue Cross Blue Shield. As I made it pretty clear in my questioning earlier today and in my comments, it is purely voluntary to apply to be a part of this system of health care. Whether it be the purchase of a xerox copy machine or whether it be other standards, the Federal Government does expect that we provide the best services available for our employees; and I guess we disagree on mandates.

You have a choice whether Blue Cross Blue Shield would like to participate in our plan or not. We are not requiring that you be one of our carriers. That is purely your option.

I think, from our discussions, Blue Cross has done quite well with probably 60 some percent of our participants and have been very profitable; and it would be your choice whether you choose to apply again in the future.

Also—I guess this would come in for Blue Cross, Mr. Gammarino—the last time we spoke, your objections were almost identical and you hadn't read the bill. And today I assume you have read the bill, but the objections haven't changed, and I appreciate your feelings and your expertise in the field.

But, currently, Blue Cross Blue Shield represents customers all over the country; and I would assume you probably have millions of participants currently in HIT, correct?

Mr. GAMMARINO. Each of our local Blue Cross Blue Shield plans, depending upon where they are in health information technology, would be providing that to their local members.

So, for example, you mentioned I believe the post-Katrina and the Texas plan who put together those records which is on short notice. They did that for their population in that particular area based upon whatever standards that they were going to employ for that local community.

The same thing could be said for each of our plans, meaning whatever local community needs that they have relative to the standards that they have felt were appropriate for that market.

Relative to the Federal Employee Benefits Program and specifically the Blue Cross Blue Shield service benefit plan, what we are engaged in is taking those individual plans, customized approaches and working with the agency to develop something that is consistent nationwide.

Mr. PORTER. So how many participants do you have nationwide currently?

Mr. GAMMARINO. We have 38 Blue Cross Blue Shield plans that participate.

Mr. PORTER. So how many of your customers would currently be able to use an HIT system?

Mr. GAMMARINO. Well, none of them are available to use the HIT system right now of the local plan. What they do, Mr. Chairman, is that we have a separate system that we have for this particular line of business because it is so large and it demands, really, customization relative to what is required to meet the needs of this customer, which is actually not just nationwide but it is worldwide.

Mr. PORTER. Again, this is why I appreciate the insurance speak. Let me ask it a different way. Blue Cross transferred how many files after Katrina?

Mr. GAMMARINO. If you are talking about the Texas Blue Cross Blue Shield, I think it was something in the order of over 700,000.

Mr. PORTER. So we know at least 700,000. Would we assume that is all that Blue Cross has in its system, is 700,000 participants?

Mr. GAMMARINO. Well, it is—in that particular area, that is what they decided to do. Nationwide, Blue Cross Blue Shield enrolls over 90 million Americans.

Mr. PORTER. How many of those will have something similar to the Texas participants?

Mr. GAMMARINO. I wouldn't know, Mr. Chairman. Each plan has their own approach to dealing with this. Some of them are probably further along than others. That is why, historically, what we have done as we roll out a program of this magnitude for this population is we work with the agency to put together a consistent uniform application for them. Otherwise, Mr. Chairman, they may be picking up the cost of each individual plan's initiative; and that is something that, at least particularly for efficiency reasons, we would want to do it in one time.

Mr. PORTER. OK. Let me ask it a different way. How many participants; 90 million in the Blue Cross and Blue Shield family are customers?

Mr. GAMMARINO. That's correct.

Mr. PORTER. Would you guess in a percentage that have this information available to them?

Mr. GAMMARINO. No. I would not want to guess. The definition of information probably reflects what they're doing for each particular plan. For example, the example you mentioned was put together for one isolated potential event, and as we know, they didn't really have to access that because the subsequent event didn't really occur at the level that they thought they needed to. So this is what—in the Texas Blue Cross and Blue Shield plan was dealing with an emergency situation. It wasn't fully integrated, for example, in the plan's local infrastructure.

Mr. PORTER. I would think that it would be good business practice for an association to know how many are participating, especially before you object. It's obvious that you don't know, or you would have answered my question; but I wonder how you can object when you don't know this information. I'm confused.

Mr. GAMMARINO. In objecting to the legislation?

Mr. PORTER. Yes.

Mr. GAMMARINO. Well, Congressman Porter, as I think I've said it in my statement, the objection is to a mandate relative to this program versus an endorsement of the approach in allowing us to

work with OPM, the agency, to develop and implement something that we think is useful and effective for this enrolled population. It hasn't shown to be beneficial, for example, for us to independently use each plan's local system because they're meeting the needs based upon what they have locally. And it may or may not be consistent with what would be applicable, Mr. Chairman, for a program of this size and the scope relative to it being nationwide.

Mr. PORTER. You talk about communities and different markets and the needs of those communities. Do you feel that if the need of the Texas community was fulfilled, that was a mandate?

Mr. GAMMARINO. No, as a matter of fact, it was just the opposite of a mandate, Mr. Chairman. They've actually took a specific instance and, based upon what they felt was appropriate, developed records that they felt would be appropriate at that time for their particular population.

Mr. PORTER. Do you think, then, that the civilian population should have different tools available to them than Federal employees?

Mr. GAMMARINO. No. No. I think, as a matter of fact, I would endorse the approach the Texas plan took relative to this FEHBP, allowing the carriers to develop records that they think are meaningful for their membership under the oversight of this body and the specific direction of the agency.

Mr. PORTER. The Federal program is really a huge associated health plan, I guess if we put it in perspective. Whether if you're in Nevada or California, you're still a Federal employee. So what you're saying is that if Nevada—one of the Blues in Nevada chooses not to do this, and California does, a Federal employee in Nevada may not have the same tools available to them to check their own records as someone living in California; is that what you're saying?

Mr. GAMMARINO. Well, right now it might be true.

Mr. PORTER. Are you suggesting it should stay that way?

Mr. GAMMARINO. No. As a matter of fact, I'm suggesting just the opposite, that working with the agency with your oversight, that we develop appropriate health records for this particular program to meet the nationwide and actually the worldwide needs of the Federal enrollees and retirees.

Mr. PORTER. Thank you. I appreciate it.

Mr. Davis.

Mr. DAVIS OF ILLINOIS. Thank you, Mr. Chairman.

Dr. Georgiou, Mr. Gammarino and Mr. Witkowski, interoperability seems to be critical if electronic health records are to be useful and work as intended. How would you ensure that the electronic records you create would be interoperable?

Mr. WITKOWSKI. Thank you, sir. What we're doing is we're starting the initiative in the Kansas City area with a group of employers, and we hope that some of the initiatives that take place may end up being a model, or it may not, but if it does not become a model on a national level, then what we've got to do is wait and see what standards do get developed and move in that direction.

So our position right now is going to be wait and see what sort of standards are there and then start complying with what gets put in place.

Dr. GEORGIOU. Yes. United Health Group certainly supports the development and application of standards as well. We also think that it's important to remain flexible as we learn about how to effectively produce personal health records, that we remain flexible in the design so that we can continue to meet marketplace and, most importantly, consumer needs to make these effective in improving health care quality and decreasing cost.

Mr. GAMMARINO. Congressman Davis, this is a big challenge, interoperability, and that's one of the reasons why we think the standards are so important before we go forward.

A number of our Blue plans are gaining experience in some areas of the country, like Arkansas, for example. They actually are employing interoperability between both the providers and the health plans, in some cases the members themselves. So we are learning. It's one reason why I value Congressman Davis, I think, your question about piloting. I really think that we have a lot to learn before we employ significant resources on this to make sure we do it right.

Mr. DAVIS OF ILLINOIS. Thank you very much.

And let me ask Mr. Fallis, Ms. Kelley and Ms. Simon, what is your response to the question of developing a pilot perhaps as a way to really move into the implementation of this activity?

Ms. KELLEY. NTU would support a pilot. I think no matter what the issue is, there are always things to be learned. I think it's clear from the work that has been done by the subcommittee and the changes that Chairman Porter has already agreed to make that we've learned things just from the beginning of this conversation. So when you actually put this in place, I'm sure there are many things to learn that would help avoid problems, many of which we have identified that we have concerns about, whether it's in the privacy arena or enforcement or all those areas. So NTU would be pleased to work with the subcommittee on a pilot.

Mr. PORTER. Ms. Simon.

Ms. SIMON. Yes, thank you. We recommend a pilot in our testimony. The last hearing when the Christiana medical system in Delaware was cited as an example of success, we thought immediately that it was quite unrepresentative of many of the large plans in FEHBP. You've got a small, relatively homogeneous community covered by one plan. In fact, for example, in Blue Cross and Blue Shield, there are hundreds of thousands of providers.

And just anecdotally, we've heard from small providers whose response to the idea of one more administrative responsibility under FEHBP would be to drop any coverage, any insurers that required that additional reporting requirement.

And we've been very, very concerned that participation in this plan on the part of the consumer be entirely voluntary, and that participation be able to be withdrawn at any time at will on the part of the participant.

Mr. PORTER. Mr. Fallis.

Mr. FALLIS. NARFEA would support a pilot program. I think inherent in all this is the necessity that we have a means to educate people about the electronic system and the fact that it can be kept private. You know, privacy is a very, very critical issue, as I mentioned earlier, with our people. We have an organization whose average age is 74. And I was at a meeting fairly recently in Florida,

and this business of HIT was mentioned, electronic records. And of course they think it's on the Internet and would be available to everybody, and quite frankly, they raised the roof, no, no, no, no, we don't want that.

So there is a barrier and a hurdle that has to be crossed with members in my organization, and that's to assure them that privacy would really be there. And that's the main issue, as far as I'm concerned.

Mr. DAVIS OF ILLINOIS. Thank you very much, Mr. Chairman.

Mr. PORTER. Thank you, Mr. Davis.

I'd like to once again address—before we go to another question—the purpose of this legislation.

Close to 100,000 people a year are dying. I support test projects, I support pilot projects, but the reason this legislation came forward is one of the downsides of Federal Government is we study things to death, and I say that 90,000 to 100,000 people a year are dying, 700,000 people are being hurt every year. And to help Blue Cross, there is 10 or 11 million of your participants in Illinois, Texas, Oklahoma, Mexico right now in the health information technology system today.

The reason I brought this forward—and I appreciate the caution, and I'm with you, and we're trying to make sure we cover all these problem areas, whether it be in the financial institutions. It's not perfect, but all this information is out there today, but the participant can't get it. I can't get my own information, and I don't think that's right.

So I appreciate the pilots. And I know we have to move forward, but if we study this for another 5 years, a half million people are going to die. How many of those are participants in the Federal system? There are so many tests happening out there, we're testing this to death. My goal was to look at the best—and you guys in the insurance industry in this room are the best in the country, if not in the world. You have the best accountants, you have the best technology, you have the best resources. You're able to make it work, if anybody can make it work, because you're already doing it. And the purpose of this legislation is if we study this for another 5 years—there's going to be another 100 million in the system, but our Federal employees aren't going to benefit from it, and I don't think that's right. I think our Federal employees deserve the best. And currently the civilian force out there, the private sector, has this available to them.

So again, I appreciate the concerns, and I struggle with, of course, trying to get answers to questions. That frustrates me. But there is 40, 50 million people today in America that are in this system. Why can't we make this work by following all the proper tests and balances with HHS and with OPM? And we have some of the best minds in the world, and certainly there is room for improvement, and, as you know, I'm open for suggestions. But my goal is to save a life. 500,000 Federal employees now in the Blue system in those States I mentioned are going to have this. Why can't folks in Nevada or Virginia have it?

So my frustration is I want to save some lives. And insurance carriers that we're working with are not insolvent, and this is not

going to be a problem for them financially. It should not be carried on to our participants because it's already being done.

So again, thank you. And to my Congresswoman that represents me in my home here, Ms. Holmes, thank you for being here. And do you have any questions?

Ms. NORTON. Thank you very much, Mr. Chairman. And I really do the best I can for you while you're in Washington.

I'm trying to get us both on the same page here. And I don't know, I think I hear from the carriers and the representatives of the employees a way to do that.

First of all, Mr. Chairman, I think what you just said in your most recent remarks is why the majority of the American people, and I think Members of Congress, yes, and Federal employees would be interested in the bill; that if we can, by providing a little information, save people's lives and improve their health care, and they're already in some kind of IT system, how come we can't somehow use it? It's pretty hard to say anything but amen to that. And as with all hard problems, it gets down to the nuts and bolts that you really get to the questions we have to ask, and that's what I want to raise here today.

I have really two concerns. These were raised previously when we have had hearings on this bill. One, of course, were the upfront costs. If you say to anybody—and we're talking about Federal employees—and there is one dime to be added to—costs keep going up or anything, except what you tell me is for health care costs, you will get the book, eggs and anything else they can find thrown at. And this whole notion about the reserves and pharmaceuticals and some nonprofits, very bothersome. We're talking about 3.1 million retirees and Federal employees, and frankly, that's what makes this idea a good one. This is your, you know, optimal control group, the Federal employees. And if somebody has to go first, why not a group like this, where we have more control than we would have in the ordinary population?

But if we have learned anything about IT, it is that the jerry-built systems will kill you. So you think you're being killed because somebody can't get your records? One of the things you don't want to do is let loose a weapon like IT that you're not absolutely sure of.

Now, Mr. Chairman, I think I heard—and I would like everybody to correct me if I'm wrong, if anyone disagrees with this—does anybody on the panel believe that the best way available for us to proceed is through some form of pilot program where we would—whatever group we may all perhaps in a hearing like this choose as the appropriate group, but would take some of these 3.1 million as opposed to all of them to begin to implement this in phases? Is there anyone who disagrees that a pilot program would be the most responsible way to begin? I just want to establish that for the record.

Let me tell you why I raise it. How short are our memories? Who remembers the prescription drugs fiasco, where the program literally fell apart on the first day? Why? Because it really had many component parts, and because IT was central to making it work. That would otherwise be known as an unintended consequence. It was not perceived in advance. In my judgment it could have been avoided if we had phased in seniors, saying everybody will be in

by X date. But we threw them all in there, and a terrible price was paid. Half the States of the United States, including the District of Columbia, ended up rescuing the Federal program.

So you will find me believing in very large part because I ran an agency—when I came to the agency it was very troubled, and what you really wanted to do, since I thought I knew what to do, was to take the whole agency and begin. And I started with 3 of the offices, and there must have been 15 in the country, and tested it out. So I really don't believe in the infallibility of government bureaucrats. I think we are like everyone else and should try everything out.

I am totally confused, Mr. Chairman, because in your case-by-case analysis you say—and I want to from the carriers particularly—certainly from the employee representatives—what is going to be made available is what is available, like carrier information is available now, and so no one knows from carrier information, for example, what the blood test is for, what the results were. That's still private information. But when I looked at this analysis—Mr. Chairman, this is in your memo to us—under carrier-based electronic health record, then I get lost, because it says that each carrier-based electronic health record must contain the carrier's health information for the particular FEHBP member enrolled to the extent that the information is necessary.

Now, then, it—and this is the part that I don't understand, and maybe the panel can help me understand. The primary purpose of section B is to, "convert claims data into a format that is useful for diagnosis and treatment," like a patient summary. But I thought the claims information was not like individual information that we would make available to your doctor, for example. See, that's who we want to save lives with; we want your doctor and all your doctors to have it. But we begin with the carrier information. But in this hand—help me out, please—useful for diagnosis and treatment. But I thought it couldn't be used for diagnosis and treatment, and that's why it's all right we can make it available because it's only claims data.

Would somebody—this just may be me, but I'm confused by this analysis of what the bill will do and what we are told that the claims information stops it doing.

Mr. PORTER. If you would yield for just a moment. I know you have a flight to catch, so if you need to go——

Mr. WITKOWSKI. I don't think I'm going to make it, sir.

Mr. PORTER. If you decide to stay——

Ms. NORTON. Are you opting out?

Mr. PORTER. He's opting in.

Dr. GEORGIOU. If I could offer maybe some clarity in an answer to your question. Carrier-based health information includes the claim submissions from all of the providers, hospitals, facilities, physicians that care for an individual patient. Each of the claims that are submitted, however, is a single event in time, and so I believe—correct me if I'm wrong, Chairman Porter, but I believe that what you would like to suggest in the bill is that all of those separate events that exist for an individual be consolidated in a way that provides a holistic picture of the individual and the conditions that are part of their history.

I don't think that any claim-based personal electronic health record should be used to practice medicine or make a diagnosis, but it could assist and support the practice of medicine and prevent errors, accelerate diagnoses and improve the quality of care.

Ms. NORTON. Do you think that the claims-based information should go first? That would be what nobody could opt in or out of, right, because we already provide that kind of information?

Dr. GEORGIOU. That information is currently available, I would expect, in all of the data bases that exist.

Ms. NORRIS. But do you really think that one could construct from that claims information a, "patient clinical summary?" And if so, why is it mandatory, why is that an invasion of privacy?

Dr. GEORGIOU. I absolutely believe that can be constructed. We actually have already constructed that for over 15 million members, and it's available today.

Ms. NORRIS. So you have already opted in because whoever has your claims information already can do a patient clinical summary from it. So what's the difference between opting in and opting out if it's mandatory, and if, in fact, the primary purpose is to use this claims data in a format useful for diagnosis and treatment, like a patient clinical summary, then why haven't you essentially opted in, because whoever has this information can, in fact, reconstruct, as it were, a clinical—a patient clinical summary?

Dr. GEORGIOU. I'm not sure I completely understand your question, but let me make a few points. No. 1 is that United Health Group would support an opt-out provision to this in this bill.

Ms. NORRIS. For the carrier——

Dr. GEORGIOU. For the carriers, yes.

And No. 2 is that an individual always has the personal choice to access it or not access that information through the portal. Did that answer your question?

Ms. NORRIS. Well, yeah, it's opting out and not opting in, of course. Yes—no, it does—what I am saying is that this says you can, in fact, use this information to, in fact, get the information I thought was not available through the claims data because you can use this information like a patient clinical summary. And the last time I looked, when you said patient clinical summary, it means that somehow you can find this private information about what, in fact, transpired. On the surface it may look like I took a blood test, but if it says that it will be used for—useful for diagnosis and treatment like a patient clinical summary, it must mean that somebody did, in fact, reconstruct what the uses are. And I just don't understand—I still don't understand if that's the case, what the difference is here between the carrier-based electronic information is and what the so-called individual information is where you have to somehow say whether you want that information released. So I am—no, you have not answered that, except by saying you could opt out of it.

Could I just ask this? You know, here we are—this opting in, opting out, and whether or not people understand what they can do and what it really means, and what can be constructed or reconstructed from the carrier information, all of these nuts-and-bolts questions I'm getting into, I think, Mr. Chairman, could be easily cleared up by just taking a portion of the work force that voluntary

agrees—perhaps even given some incentives, I don't know what they would be—but perhaps voluntarily agrees to test this out so that some of these questions simply answer themselves. Because we have real-time, real-life people, we see where the mistakes are made, but on such a level—with such a group sufficiently small that we don't do harm to as many as 3 million employees just through the carrier-based data alone, for example.

So I don't know see yet the answers to the questions I've raised, others have raised, and what looks to be the consensus of employees and carriers alike is not try to focus in on a target group to test this new and very wonderful idea, but not to subject every Federal employee at one time to it, prescription-drug style that is so recently in our minds. Thank you, Mr. Chairman.

Mr. PORTER. Thank you very much. I have another 20 or 30 questions to ask, but let me say thank you very, very much for your time. And many of you have spent literally hours on this project, and I appreciate that.

This program—and possibly I'm not always making myself as clear as I would like. I would just like 8 or 9 million Federal employees to have available to them what 15 million have currently at United HealthCare, or the 10 or 20 million—maybe it's 50 at Blue Cross and Blue Shield, I'm not sure, a million and a half. I would like Federal employees to have those same benefits.

And I agree with my colleagues and every one of you that privacy is critical. I believe that keeping the premiums where they are, if not less, is a priority. But I think I said it probably earlier that our Federal employees deserve what the private sector can have and our retirees deserve, and that I would hope that this voluntary program that I'm proposing could move forward and change health care for millions of Federal employees and health care across the country. And I appreciate all of you, GEHA, United HealthCare, for expressing support and willingness to work and move forward.

You know, of course, I pick on you, Mr. Gammarino. It's difficult for me to hear no on our first meeting and still hear no today even before you read the legislation. So I see other health carriers stepping up to the plate because they think they want the business because it's profitable business, but we still have some time, and I'm still open for ideas as we fine-tune this.

And to our employees, Ms. Simon, I understand the concern of families. I mean, they don't want to be a test, they want the best, and they don't want to pay more. I understand that. I certainly understand—I understand the employees more than I understand the insurance industry's objections, but we're going to try to do everything we can to address those concerns, and I appreciate your comments.

So I want to thank you all. This is very historic, and I think that collectively we can do some great things. And to my committee, I know that they've had other meetings to go to but it's been a very thoughtful process, and I appreciate all of you being here and being here late in the evening.

So the meeting is adjourned. So thank you very much.

[Whereupon, at 6:01 p.m., the subcommittee was adjourned.]

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